

# **EXHIBIT A – OWENS & MINOR COMPLAINT**

**UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF VIRGINIA  
RICHMOND DIVISION**

OWENS & MINOR, INC. and	§	
OWENS & MINOR FLEXIBLE	§	Case No. 3:24-cv-820
BENEFITS PLAN	§	
	§	
V.	§	First Amended Complaint
	§	
ANTHEM HEALTH PLANS OF	§	
VIRGINIA, INC. D/B/A ANTHEM	§	[Jury Trial Demanded]
BLUE CROSS AND BLUE SHIELD	§	

**PLAINTIFFS' FIRST AMENDED COMPLAINT**

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Plaintiff OWENS & MINOR, INC., individually and on behalf of Plaintiff OWENS & MINOR FLEXIBLE BENEFITS PLAN,<sup>1</sup> files this First Amended Complaint against ANTHEM HEALTH PLANS OF VIRGINIA, INC. D/B/A ANTHEM BLUE CROSS AND BLUE SHIELD, and in support thereof states the following:

## **INTRODUCTION**<sup>2</sup>

### **I. CRUX OF THE CASE: A FOX IN THE HENHOUSE**

1. Like many employers across the country, Plaintiff Owens & Minor, Inc. sponsors a self-funded healthcare plan to provide quality healthcare to its employees and their families. Owens & Minor engaged Defendant to administer the millions of dollars it and its employees paid into the Plan. In September 2021, Plaintiff requested its Plan data from Defendant so that it could ensure that Defendant was faithfully administering the Plan's assets. Following this request, Defendant transformed what should have been a simple transfer of the *Plan's* data to the *Plan's* sponsor, into a nearly two-year game of "hide the ball."

2. Defendant first claimed that it *could* not provide the requested data, and then said that it *would* not. After retaining outside counsel, Defendant said that it would provide the data only to later retract that promise. Eventually, Plaintiff had to sue Defendant to

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<sup>1</sup> In this Complaint, "Plaintiff" refers collectively to Owens & Minor, Inc. in its individual capacity and in its capacity as fiduciary representative of the Owens & Minor Flexible Benefits Plan unless otherwise provided expressly or by context. "Owens & Minor" refers specifically to Owens & Minor, Inc. "Plan" refers specifically to Owens & Minor Flexible Benefits Plan.

<sup>2</sup> Plaintiff files this First Amended Complaint to address certain arguments in Defendant's memorandum in support of its motion to dismiss, ECF 14. While Plaintiff disagrees that Defendant's arguments support dismissal of any cause of action, Plaintiff intends to further clarify and allege facts in support of its claims.

obtain its own data.<sup>3</sup> Now that Plaintiff has a portion of that Plan data and has had some opportunity to analyze it, it is clear why Defendant fought so hard to prevent Plaintiff from accessing it. Plaintiff's analysis to date has revealed tens of millions of dollars of damages to Plaintiff as a result of Defendant's neglect and misconduct. Plaintiff suspects the damages will grow significantly upon receipt of the remaining data which continues to be withheld.

3. As is well known, healthcare in America is facing a severe crisis. Skyrocketing costs have made it increasingly difficult for hard-working Americans to afford essential medical care or prescription drugs.<sup>4</sup> Health plan administrators—like Defendant—are at the root of the problem.

4. Employers across the country, like Plaintiff, have hired and trusted third-party administrators to manage and safeguard the assets of their self-funded health insurance plans with the utmost care. Although these administrators are fiduciaries to the plans and the plans' beneficiaries, nationwide reports have revealed widespread misconduct. Specifically, investigations have uncovered that administrators' acts and omissions have resulted in the misappropriation and waste of billions of plan dollars. Hard-working Americans bear the cost of such misconduct in the form of ever-increasing healthcare costs and premiums.

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<sup>3</sup> *Owens & Minor, Inc., et al. v. Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield*, Case No. 3:23-cv-00115-REP, E.D. Va.

<sup>4</sup> Aimee Picchi, *Americans spend more on health care than any other nation. Yet almost half can't afford care.*, CBS NEWS (July 17, 2024), available at <https://www.cbsnews.com/news/health-care-almost-half-of-americans-struggle-to-afford-medical-care/> (last accessed Nov. 15, 2024).

5. Defendant served as a fiduciary under the Employee Retirement Income Security Act (**ERISA**) with respect to funds it held, controlled, and used to pay healthcare costs for participants and beneficiaries in Plaintiff's self-funded healthcare plan. "ERISA guarantees plan beneficiaries a fiduciary who acts solely in their interests"; thus, "a fiduciary laboring under a conflict of interest must act as if [it] is free of such a conflict." *Edmonds v. Hughes Aircraft Co.*, 145 F.3d 1324, 1998 WL 228200, at \*8 (4th Cir. 1998) (some quote omitted). "Free" in the ERISA sense is "an absolute." *Id.* ERISA therefore leaves no room for "balancing" of a fiduciary's interests against those of plan participants and beneficiaries. *Id.* "ERISA commands undivided loyalty" by Defendant. "If faithfully discharging such a duty appears especially arduous, that is because it is." *Id.* ERISA duties of care and integrity remain the highest known. *Id.*

6. Relying on Defendant's assurances that it would faithfully serve as an ERISA fiduciary, Plaintiff trusted Defendant—a purportedly reputable company with a household name—with millions of dollars intended to fund healthcare for employees of Owens & Minor and their families enrolled in the Plan. Defendant sought out and readily accepted the responsibility of a fiduciary with respect to those funds because Defendant stood to earn significant sums in fair, transparent payment for its services. Unbeknownst to Plaintiff, Defendant wanted more than fair payment. And unbeknownst to Plaintiff, Defendant had no interest in protecting the Plan as a fiduciary must under the law.

7. Defendant willingly undertook the duty to discharge its responsibilities solely in the interests of those employees and their families.

8. Defendant willingly agreed to discharge its duties for the exclusive purpose of providing benefits to those employees and their families.

9. Defendant willingly undertook the duty to defray expenses incurred by the Plan.

10. Defendant willingly undertook the duty to exercise the care, skill, prudence, and diligence of a reasonable fiduciary and TPA.

11. However, Defendant's boundless avarice and neglect caused it to violate these duties on all fronts. Reports of widespread TPA misconduct caused Plaintiff concern. Following President Reagan's oft-stated mantra, "trust but verify," Plaintiff sought to verify that Defendant executed its duties according to ERISA's unbending standards and that Plaintiff itself was not a victim of misconduct. When Plaintiff began its investigation, it quickly realized that Defendant's disclosures relating to the Plan were not sufficient to ascertain whether Defendant's performance satisfied its relevant duties. Part of the information needed was the Plan's claims data. But Defendant refused to disclose the Plan's claims data, which was essential to confirm Defendant had not wasted funds, defrauded Plaintiff, or abused Plaintiff's trust. Defendant even forced Plaintiff to sue Defendant to obtain this information—information that Defendant claimed Plaintiff had no right to view.

12. But Plaintiff has a portion of that data now. That data reveals Defendant used Plan assets for its own purposes and is not worthy of even minimal levels of trust. Specifically, it demonstrates how Defendant used Plan funds to enrich itself and its affiliated companies and medical providers to the Plan's detriment. The data further



demonstrates that Defendant sought to increase the costs of Plan administration—or simply made no effort to control Plan costs—because doing so increased Defendant’s profits. Defendant acted contrary to the fiduciary standards imposed by ERISA by, among other things, (i) paying more for healthcare claims than was even billed, (ii) securing kickbacks from providers and affiliated intermediaries, (iii) double-paying claims, and (iv) pocketing rebates belonging to Plaintiff.

13. As a result, the Plan has incurred significant losses paid for by employees of Owens & Minor and the company itself. Importantly, Defendant has continued to withhold other information from Plaintiff that would enable it to calculate the full extent of losses it has suffered as a result of Defendant’s misconduct. Plaintiff anticipates that, upon reviewing that information in discovery, Defendant’s misconduct and Plaintiff’s losses will become fully exposed. Plaintiff files this suit to recover its losses and claw back Defendant’s ill-gotten gains.

## **II. EMPLOYERS SPONSORING HEALTHCARE PLANS FOR EMPLOYEES ALMOST UNIVERSALLY HIRE THIRD PARTY ADMINISTRATORS LIKE DEFENDANT.**

14. Throughout the country, employers large and small provide healthcare benefits for their employees. Many employers, including Owens & Minor, provide health benefits through self-funded plans, whereby the plan funds employees’ and their beneficiaries’ healthcare expenses primarily from employer and employee contributions.

15. As sponsors and plan administrators of self-funded plans, employers owe fiduciary duties under ERISA to the plans and to the employees and beneficiaries covered by those plans. ERISA allows plan sponsors to delegate those fiduciary responsibilities to

third parties who possess the expertise, infrastructure, and systems to manage certain aspects of those plans. Thus, to manage the plan's claims administration, employers generally hire third party administrators based on their advertised ability to manage the plan.

16. For these reasons, there is a significant and lucrative market for third party administrators (**TPAs**). TPAs specialize in the healthcare benefits business. They possess the expertise, personnel, and systems to price, administer, and process healthcare claims. TPAs like Defendant market themselves as possessing the expertise and integrity necessary to serve as fiduciary plan administrators. Thus, employers sponsoring self-funded healthcare plans generally entrust their plans' assets and the health of their employees to TPAs.

17. In 2017, Owens & Minor hired Defendant Anthem, a TPA who purports to specialize in the administration of self-funded plans and to manage healthcare claims for plans with the level of care and loyalty demanded by ERISA. In doing so, Plaintiff entrusted Plan assets and the care of its employees to Defendant. Nevertheless, as Plan sponsor, administrator, and named fiduciary, Owens & Minor retained duties under ERISA to monitor Defendant, protect Plan assets, and oversee the quality of care provided to its employees and beneficiaries. Owens & Minor reasonably expected Defendant to comply with the law and carry out its duties solely in the interest of the Plan's participants and beneficiaries and for the sole purpose of providing healthcare benefits to them while defraying the expenses of the Plan. Defendant, however, did just the opposite, because violating the law generates more profits for Defendant and its affiliates.

### III. IN RECENT YEARS, PLAINTIFF GREW MORE SENSITIVE TO THE THREAT POSED BY TPA FRAUD, WASTE, AND ABUSE.

18. The past few years have generated reports of wrongdoing that justify Plaintiff's efforts to investigate Defendant's management of the Plan. These reports detail several instances where opportunistic claims administrators employed illegal or unethical means to obtain windfall profits at the expense of self-funded plans and taxpayers alike. As an example, one report claimed certain claims administrators illegally incentivized healthcare providers to report that Medicare Advantage patients are sicker than they actually are, because the insurers received more income for patients with more serious documented conditions. According to a *New York Times* report, the misconduct caused between \$12 billion and \$25 billion in overpayments by Medicare in 2020 alone.<sup>5</sup>

19. Other developments further justify Plaintiff's efforts to carefully assess Defendant's claims administration practices.<sup>6</sup> One report revealed that merely replacing a claims administrator saved a governmental entity such a large sum of money that there simply had to be waste or other problems in the claims administration processes.<sup>7</sup> The news

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<sup>5</sup> Reed Abelson and Margot Sanger-Katz, *'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions*, N.Y. TIMES (Oct. 8, 2022) available at <https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html>, last visited Oct. 10, 2022.

<sup>6</sup> See, e.g., *Employer Held Liable for Service Provider's Error*, J.D. SUPRA (Dec. 31, 2020) available at <https://web.archive.org/web/20201231211429/https://www.jdsupra.com/legalnews/employer-held-liable-for-service-89209/#expand/>, last visited Nov. 17, 2024.

<sup>7</sup> *TRS says it will save millions on new health administrators, assures members of minimal plan impacts*, TEXAS AFT (Feb. 27, 2020), available at <https://web.archive.org/web/20221004070344/https://www.texasaft.org/government/trs/trs-says-it-will-save-millions-on-new-health-administrators-assures-members-of-minimal-plan-impacts/>,

was saturated with stories regarding the harm that TPAs can cause.<sup>8</sup> In fact, the American Medical Association estimates that commercial health insurers have an average claims-processing error rate of 19.3 percent, which creates excess costs of \$17 billion annually.<sup>9</sup> Another report, which comes from the nonpartisan Council on Health Care Spending and Value, opined that excess administrative costs wasted between \$285 billion and \$570 billion in healthcare spending in 2019 alone.<sup>10</sup>

20. The information reported in those articles and similar reports demonstrates that Plaintiff's sensitivity to the risks potentially posed by its Plan's TPA was well-founded. These reports support Plaintiff's heightened efforts since 2021 to assess Defendant's performance and to ensure Defendant honored its fiduciary duties to the Plan, participants, and beneficiaries.

#### **IV. DEFENDANT ACTIVELY FRUSTRATED PLAINTIFF'S ATTEMPTS TO ACCESS AND ANALYZE THE PLAN'S CLAIMS DATA.**

21. In September 2021, Plaintiff requested its Plan's claims data and information from Defendant in order to assess the Plan's performance financially and with

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last visited Nov. 17, 2022 (Texas teacher retirement system saved hundreds of millions of dollars by replacing claims administrator).

<sup>8</sup> See, e.g., Brendan Pierson, *Mass. Blue Cross sued for 'mismanagement' of state employee health plan*, REUTERS (Mar. 29, 2021), available at <https://www.reuters.com/article/health-blue-cross/mass-blue-cross-sued-for-mismanagement-of-state-employee-health-plan-idUSL1N2LR2IC>, last visited Nov. 17, 2024 (discussing litigation involving allegations of self-dealing).

<sup>9</sup> *AMA blasts insurers on 19.3 percent claims error rate*, HEALTHCARE IT NEWS (June 20, 2011), available at <https://www.healthcareitnews.com/news/ama-blasts-insurers-193-percent-claims-error-rate>, last visited Nov. 17, 2024.

<sup>10</sup> *The Role Of Administrative Waste In Excess US Health Spending*, HEALTH AFFAIRS (Oct. 6, 2022), available at <https://www.healthaffairs.org/content/briefs/administrative-waste-excess-health-spending>, last visited Nov. 17, 2024.

respect to the adequacy of care that Plaintiff's employees and their beneficiaries received. What should have been a simple transfer of *the Plan's* information from Defendant to Owens & Minor—the Plan sponsor, named fiduciary, and administrator—turned into a year-long trail of emails and other correspondence, littered with Defendant's excuses, arbitrary conditions, and illusory promises. For example, Defendant would agree to provide the information and then renege, citing some obscure, inapplicable condition in its form agreement, which Defendant had carefully crafted in an effort to illegally sidestep its fiduciary duties. Of course, to any extent Defendant's crafty contract provisions purport to relieve Defendant of its fiduciary responsibilities, ERISA invalidates those provisions.

22. Determined to obtain the Plan's information, Plaintiff patiently endured Defendant's parade of promises, delays, obfuscation, and excuses. Plaintiff even attempted to satisfy some of Defendant's arbitrary and baseless conditions. Despite Plaintiff's year-long efforts to obtain claims data belonging to the Plan it sponsors and oversees, Defendant continued to block Plaintiff from even the most basic information it needed to assess the Plan's performance.

23. For example, Plaintiff repeatedly requested that Defendant provide the most comprehensive data in Defendant's possession regarding each claim paid by the Plan, including the "Billed Amount," "Excluded Amount," and "Allowed Amount" for each claim. This basic Plan information was crucial for Plaintiff to understand whether Defendant was causing Plan funds to be spent improperly, such as causing the Plan to pay more than billed charges for medical claims. After months of requesting this information,

Defendant eventually told Plaintiff that it “won’t release” this basic data because it might reveal their “confidential” arrangements with providers:

From: Turner, Hannah <[hannah.turner@anthem.com](mailto:hannah.turner@anthem.com)>  
 Sent: Monday, February 21, 2022 4:58 PM  
 To: Boykin, Timothy <[Timothy.Boykin@owens-minor.com](mailto:Timothy.Boykin@owens-minor.com)>  
 Cc: Jones, Chloe <[Chloe.Jones@owens-minor.com](mailto:Chloe.Jones@owens-minor.com)>; Taylor, Charles J. <[charles.taylor@anthem.com](mailto:charles.taylor@anthem.com)>  
 Subject: [EXTERNAL] RE: OMI Anthem Data Request - Medical

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe. If you question any part of this email, please forward to [Phishing@Owens-Minor.com](mailto:Phishing@Owens-Minor.com)

Hi Tim and a late Happy New Year! – Thanks for your outreach. I’m happy to have our data team leaders review this request. Out of the gate, I will say that we won’t release both allowed and paid/billed. This would expose our confidential discounts/payment contracts aligned to each provider. Are you comfortable removing one of those before I submit to our team for review? If yes, which would you be willing to remove?

Thanks,  
 Hannah  
 Anthem, Inc.  
 Hannah R. Turner, Client Executive, National Accounts

(emphasis added).

24. After Plaintiff pushed back against Defendant’s refusal to provide Plaintiff with its *own* Plan data, and only after Plaintiff engaged outside counsel to take steps to obtain the data through the judicial process if necessary, Defendant pretended to relent. In August 2022—nearly a year after Plaintiff first started trying to obtain the Plan data—Defendant wrote that it would provide the requested data fields after all, subject to the execution of a confidentiality agreement:

Further, we will continue to exclude DME claims for services outside of Owens & Minor, but agree to include the following data elements in the data set for the sole and permitted purpose to be stated on the DRSF:

1. Allowed Charges
2. Billed Charges
3. Excluded Charges
4. BlueCard data – related to claims detail requested in non-Anthem states

I look forward to your confirmation on intended recipient of the requested data.

My Best,  
Hannah  
**Hannah R. Turner**  
Client Executive, Anthem National Accounts

25. *However*, when Defendant sent the draft confidentiality agreement and final data field list to Plaintiff for execution, it became clear that Defendant was reneging on its promise to provide all of the requested claim information. Once again, the “Billed Amount” and “Allowed Amount” data fields were removed from the list of items that Defendant said it would produce. The confidentiality agreement also included a broadly worded “Disclaimer and Exculpation” provision that purported to disclaim the accuracy of the claims information Defendant would provide, and even *release* Defendant from *all liability* related to any “erroneous, inaccurate, or incomplete information.” Plaintiff rejected Defendant’s attempt to walk back its commitment to provide these data fields and to shield itself from liability.

26. Defendant’s actions hindered Plaintiff’s ability to carry out its own fiduciary duties to the Plan, Plan participants, and beneficiaries as they relate to monitoring and assessing Defendant’s claims management practices and performance of its fiduciary duties. In other words, only Defendant itself had the capability to determine whether it was meeting ERISA’s standards.

27. Plaintiff sued Defendant in 2023 to obtain access to its Plan's claims data. Now, Plaintiff has a portion of that data and has had some opportunity to analyze that data. That analysis revealed Defendant violated its ERISA duties in numerous—and costly—respects. Plaintiff now seeks recovery of losses caused by Defendant's violations.

28. Even now, Defendant continues to withhold Plan information that is necessary for Plaintiff to assess the full scope and impact of Defendant's wrongdoing.<sup>11</sup> This information includes, but is not limited to the following:

- (i) Defendant's payment processing rules and claim payment methodologies applicable to the Plan, which will allow Plaintiff to determine the accuracy of certain payments Defendant caused the Plan to make;
- (ii) Defendant's agreements with providers, Pharmacy Benefit Managers and other third-parties (such as affiliated pharmacies and providers, insurance networks, and vendors) applicable to the Plan, which will enable Plaintiff to determine the accuracy of certain payments and the full extent of Defendant's self-dealing and misappropriation of Plan assets; and
- (iii) information regarding the amount of Plan funds that were actually paid to pharmacies on Plan members' pharmaceutical claims, so that the Plan

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<sup>11</sup> Other plan sponsors have faced similar stonewalling. For example, Anthem was hired by the state of Indiana to administer certain state Medicaid programs. During a recent audit of pharmaceutical claims for those programs, Anthem failed—even in the face of a Civil Investigative Demand issued by the Indiana Attorney General—to provide the information necessary for Indiana to complete its audit. *See* [https://iga.in.gov/publications/agency\\_report/State%20PBM%20Contracts.pdf](https://iga.in.gov/publications/agency_report/State%20PBM%20Contracts.pdf), at 20, last visited Feb. 6, 2025.



can calculate how much more Defendant caused the Plan to pay out for those drugs as compared to the amount that the pharmacies actually charged.

### **PARTIES**

29. Plaintiff Owens & Minor, Inc. is a Virginia corporation headquartered in Mechanicsville, Virginia. Plaintiff employs thousands of people across the United States. Plaintiff is the sponsor and named fiduciary for Plaintiff Owens & Minor Flexible Benefits Plan (**Plan**). The Plan is a welfare benefit plan under ERISA that provides healthcare coverage for Plaintiff's employees and their beneficiaries. The Plan is "self-funded," meaning that the Plan is primarily funded by contributions from Plaintiff Owens & Minor and Plan participants— *i.e.*, Owens & Minor's employees.

30. Defendant Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield is a Virginia corporation.

### **THE SIGNIFICANCE OF THE ADMINISTRATIVE SERVICES AGREEMENT AND THE PARTIES' RESPECTIVE CONDUCT**

#### **I. THE ADMINISTRATIVE SERVICES AGREEMENT GENERALLY**

31. The parties' Administrative Services Agreement (**ASA**) conclusively establishes that Defendant is a fiduciary under ERISA.

32. Plaintiff required the services of a TPA to administer the Plan. Plaintiff is not a claims administrator and does not possess the expertise, personnel, or systems necessary to administer the Plan's claims. Based on Defendant's various representations detailed below, Plaintiff engaged Defendant as the Plan's TPA and executed the ASA, delegating

much of Plaintiff's fiduciary responsibilities under the Plan to Defendant. Defendant knew Plaintiff lacked the ability to serve as the Plan's claims administrator, and Defendant knew that Plaintiff relied on Defendant's assurances regarding its services and integrity. Thus, Defendant and Plaintiff agreed—through the ASA—that Defendant would serve the Plan as its fiduciary TPA.

33. The ASA became effective on June 1, 2017, **Ex. A** at 1,<sup>12</sup> and Plaintiff began suffering losses immediately.<sup>13</sup>

34. In the ASA, the parties acknowledged that Plaintiff “is the sponsor of a self-funded Group Health Plan . . . providing . . . health care benefits to certain eligible employees and their qualified dependents.” **Ex. A** at 1. The parties agreed that Defendant would “administer certain elements of [Plaintiff's] Group Health Plan.” *Id.* The ASA also identified the Plan as an ERISA plan. *Id.*

35. Plaintiff has complied with all aspects of the ASA and other agreements that comprise the ASA and govern the relationships among the Plan, Owens & Minor, and Defendant.

## **II. THE PARTIES ARE ERISA FIDUCIARIES.**

36. Defendant and Owens & Minor are both Plan fiduciaries. Owens & Minor is a named fiduciary and the Plan's sponsor and administrator. Defendant is a functional

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<sup>12</sup> While this ASA has been renewed and amended through the years, the relevant portions, except for certain performance guarantees and other more minor provisions, have remained static. Relevant portions of the ASA have been highlighted for ease of reference.

<sup>13</sup> The parties executed a tolling agreement that permits Plaintiff to recover all damages caused back to the effective date notwithstanding the statutory limitations period under ERISA and other applicable law.

fiduciary and has expressly assumed fiduciary duties to the Plan at issue here.

37. ERISA fiduciaries are either “named” or “functional.” A named fiduciary “means a fiduciary who is named in the plan instrument, or who, pursuant to a procedure specified in the plan, is identified as a fiduciary (A) by a person who is an employer or employee organization with respect to the plan or (B) by such an employer and such an employee organization acting jointly.” 29 U.S.C. § 1102(a)(2). There are three general categories of functional fiduciaries defined by ERISA:

[A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan *or* exercises any authority or control respecting management or disposition of its assets,

(ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, *or* has any authority or responsibility to do so, *or*

(iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated [as fiduciary] under section 1105(c)(1)(B) of this title.

29 U.S.C. § 1002(21)(A) (emphasis added). Defendant is a “fiduciary” under one or more of these definitions.

**A. BY VIRTUE OF ITS ROLE AS THE PLAN'S TPA, DEFENDANT POSSESSED AND EXERCISED CONTROL OVER PLAN ASSETS AND OVER PLAN ADMINISTRATION AND MANAGEMENT.**

38. As noted above, the Plan is self-funded. Thus, Plan assets represent contributions by Owens & Minor, its employees, and its former employees. Those contributions benefit the Plan, Plan participants, and beneficiaries by paying healthcare claims for participants and beneficiaries. Plaintiff represents to participants and beneficiaries that Owens & Minor's and the participants' contributions secure the healthcare benefits promised to them by Plaintiff. The amount of contributions is based in large part on Plan costs and expenditures each year. This is a common-sense proposition given that the Plan directly pays for healthcare claims, which Defendant administered for the Plan. Defendant assumed a fiduciary role by accepting and exercising authority, control, and discretion over plan management and assets.

39. The ASA expressly names Defendant as a Plan fiduciary with respect to key functions of the Plan and identifies Defendant as a functional fiduciary with respect to other actions:

Pursuant to Section 405(c)(1) of ERISA, *[Plaintiff] delegates to [Defendant] fiduciary authority to determine claims for benefits under the Plan* as well as the authority to act as the appropriate fiduciary under Section 503 of ERISA to determine appeals of any adverse benefit determinations under the Plan. *[Defendant] shall administer complaints, appeals and requests for independent review according to [Defendant's] complaint and appeals policy, and any applicable law or regulation, unless otherwise provided in*

the Benefits Booklet. In carrying out this authority, *[Defendant] is delegated full discretion to determine eligibility for benefits under the Plan and to interpret the terms of the Plan.* [Defendant] shall be deemed to have properly exercised such authority unless a Member proves that [Defendant] has abused its discretion or that its decision is arbitrary and capricious. *[Defendant] is a fiduciary of the Plan only to the extent necessary to perform its obligations and duties as expressed in this Agreement* and only to the extent that its performance of such actions constitutes fiduciary action under ERISA.

**Ex. A** at 4, art. 2.c (emphasis added). Consistent with the broad scope of this provision, Defendant possessed and exercised full, unilateral, unfettered discretion and control with respect to (i) determining how much the Plan would pay for each prescription and medical claim; (ii) determining whether each claim fell within the scope of benefits covered by the Plan; (iii) determining the number of units of prescriptions and medical services for which the Plan would pay with respect to individual claims and treatment plans of each participant and beneficiary; (iv) determining whether and how to review obvious and reasonably identifiable overpayments by the Plan, duplicate claims, claims for uncovered services, claims lacking evidence of proper certification, claims based on coding errors, and claims for services not actually rendered; (iv) determining whether the services underlying the claims were properly coded under generally acceptable coding guidelines such that the claim should be paid with Plan assets; and (v) determining the amount of Plan money Defendant would use to pay claims.

40. The ASA assigned Defendant the duty and right to process claims and “to determine the amount” that “is due and payable” according to *Defendant’s* “medical policies and medical policy exception process, its definition of medical necessity, [and] its precertification and/or preauthorization policies.” **Ex. A** at 3, art. 2.b (emphasis added). Thus, Defendant possessed authority—which it exercised during all relevant times—to unilaterally commit Plan funds to pay healthcare claims.<sup>14</sup>

41. Defendant enjoyed discretion with respect to “[t]he amount charged” against the Plan. **Ex. A** at 2 (“PAID CLAIM”). For instance, the ASA purports to grant Defendant discretion to pay a vendor more than actual billed charges for a particular service or supply. *Id.* § 1. It permitted Defendant to decide the reimbursement methodology for claims without express regard to cost. *Id.* And it required the Plan to pay Defendant for claims “without regard . . . to whether such payments are increased or decreased by the . . . achievement of, or failure to achieve, certain specified goals, outcomes or standards adopted by [Defendant].” *Id.* (emphasis added).

42. Defendant exercised extensive control, authority, and discretion over the Plan and its assets through Defendant’s contractual arrangements with providers. Both in practice and under the ASA, Defendant exercised absolute control over reimbursement arrangements with providers, which directly impacted both the amounts paid by the Plan and the quality of healthcare provided under the Plan. *See, e.g., Ex. A* at 5, art. 2.s.

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<sup>14</sup> Defendant’s actions to withhold Plan information from Plaintiff and claim that Plaintiff is not entitled to such information, as discussed herein, emphasize Defendant’s authority over the Plan and its assets.

(“[Defendant] shall have the authority, in its sole discretion, to build and maintain its Provider network on its own behalf. . . . [Defendant] shall be solely responsible for . . . negotiating rates with Providers or auditing Providers. . . .”), art. 2.o (Defendant’s contracts with providers, as Defendant may amend them from time to time, will be used to administer and price claims). This control extends to pharmaceutical benefits paid with Plan assets. *See, e.g., Ex. A* at 12, art. 14.a.1 (“[Defendant] shall determine, in its sole discretion, which pharmacies shall be Network Pharmacies, and the composition of Network Pharmacies may change from time to time.”); art. 14.a.2 (Plan “shall” adopt the formulary that governs, among other things, the amount the Plan pays for prescription drugs).

43. Defendant also enjoyed control and discretion over sums it retained from the difference of amounts paid by the Plan for prescription drugs and the amount actually invoiced for prescription drugs. *Ex. A* at 2, § 2.

44. Defendant enjoyed discretion and control with respect to settling claims and other disputes that would then be charged against the Plan. *Ex. A* at 2, § 5.

45. Defendant’s control over Plan assets is extensive. Defendant, based on its control and discretion described above, unilaterally determines the amounts to be paid by the Plan for healthcare claims. *See, e.g., Ex. A* at 2-3 (“PAID CLAIM”). Under the ASA, Defendant is authorized to take control of Plan monies and apply them to amounts Defendant determines are due. Under the ASA, the Plan must pay those sums, which are not subject to dispute by Plaintiff, on a weekly basis, and the ASA authorizes Defendant to take that money from the Plan through an automated clearing house (ACH) “pull”: “Anthem will initiate an ACH demand debit transaction that will withdraw the amount due

from a designated Employer bank account no later than three (3) business days following the Invoice Due Date.” **Ex. A** at 21-22, schedule A § 4.

46. Other documents mirror these ASA provisions:

[Defendant] shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, *to determine all questions arising under the Plan*, to resolve Member appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. [Defendant] has complete discretion to interpret the Benefit Booklet. *The Claims Administrator’s<sup>15</sup> determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan’s Maximum Allowed Amount.*” **Ex. B**, 2020 SPD at 84. (emphasis and footnote added).<sup>16</sup>

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<sup>15</sup> “Claims administrator” refers to Defendant Anthem. **Ex. B**, 2020 SPD at 93.

<sup>16</sup> “SPD” refers to Summary Plan Description or the Medical Benefit Booklet attached as exhibit B. Relevant portions of the SPD have been highlighted for ease of reference.



47. The SPD describes the “maximum amount of reimbursement *[Defendant]* will allow for services and supplies” and refers to Defendant’s determination of the maximum allowed reimbursement for particular services. **Ex. B**, 2020 SPD at 62-63 (emphasis added).

48. With respect to out-of-network claims, Defendant acknowledged that it established, “at its[] discretion,” the fee schedule/rate for those services. **Ex. B**, 2020 SPD at 63.

49. The Plan documents make clear that all monies committed by Defendant to fund claims belong to the Plan. For instance, Defendant has repeatedly disclaimed any obligation for payment of claims and concedes that monies Defendant applies to pay claims belong to the Plan. *See Ex. B*, 2020 SPD at 2, 93. Indeed, Defendant represents that it “does not assume any financial risk or obligation with respect to claims.” **Ex. B**, 2020 SPD at 93. The Plan assumed all financial risk while Defendant retained control and discretion to administer the Plan and allocate its assets.

**B. DEFENDANT’S DISCRETION AND CONTROL EXTENDED TO RECOVERY OF MONIES IMPROPERLY PAID BY THE PLAN OR OTHERWISE OWED TO THE PLAN.**

50. Defendant’s control, authority, and discretion over Plan management, administration, and assets extended beyond the value it allowed and paid on claims in the first instance. With respect to Defendant’s authority to pursue recovery of sums caused by its overpayment of claims, Defendant “shall determine which recoveries it will pursue, and in no event will *[Defendant]* pursue a recovery if it reasonably believes that the cost of the collection is likely to exceed the recovery amount or if the recovery is prohibited by law or

an agreement with a Provider or Vendor.” **Ex. A** at 11, art. 13.e. With respect to overpayment discovered in Plan-initiated audits, “[a]ny errors identified as the result of the audit shall be subject to [Defendant’s] review and acceptance prior to initiating any recoveries of Paid Claims.” **Ex. A** at 10, art. 12.d.<sup>17</sup>

51. Defendant’s extensive control and discretion with respect to audits likewise evidences unlimited control and authority over Plan assets vis-à-vis payment of claims. As alleged above, even if an audit shows that claims were improperly paid, the Plan can make no recovery of its assets without “[Defendant’s] review and acceptance” of the audit results. **Ex. A** at 10, art. 12.d. The ASA purports to grant Defendant extensive control over the audit process, including selection of the auditor and parameters of the audit. *See generally* **Ex. A** art. 12. To the extent Defendant recovers Plan monies through its own audit, it exercises extensive control over whether and how to even pursue recoveries and over the amount of those recovered monies that return to the Plan. *See* **Ex. A** arts. 13.d-e.

52. Further, “[Defendant] may, but is not required to, readjudicate Claims or adjust [Plan participants’ and beneficiaries’] cost share payments related to the recoveries made from a Provider or a Vendor.” **Ex. A** at 11, art. 13.e.

**C. PLAINTIFF OWENS & MINOR IS THE PLAN SPONSOR AND A FIDUCIARY WITH STANDING TO PROSECUTE ERISA CLAIMS ON THE PLAN’S BEHALF.**

53. The ASA identifies Plaintiff as the Plan sponsor, named fiduciary, and as the party with primary discretion and authority over all aspects of the Plan. **Ex. A** at 1 and 7,

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<sup>17</sup> Similarly, “settlements of reimbursement disputes brought by Providers do not require the approval of [Plaintiff].” **Ex. A** at 13, art. 16.e.

art. 3.b. (acknowledging that “[Plaintiff] retains all final authority and responsibility for the Plan,” which would necessarily include efforts to recover Plan losses caused by Defendant).

54. Indeed, as the sponsor and named fiduciary of the Plan, Plaintiff is afforded discretion and control over Plan assets and management of the Plan. Plaintiff’s fiduciary role extends to exercising discretion over and management of TPAs such as Defendant. Relevant here is Plaintiff’s authority under the Plan—and its duty to the Plan and Plan beneficiaries and participants—to engage and monitor TPAs and seek recovery of any losses that TPAs cause to the Plan.

55. Plaintiff’s review of its Plan’s claims data reveals Defendant violated its duty to manage the Plan with the requisite prudence and “solely in the interest of the participants and beneficiaries and (A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan.” *See* 29 U.S.C. §§ 1104(a)(1), 1105(a) and (c). Recovering losses incurred by the Plan caused by Defendant’s violations lies at the heart of Plaintiff’s authority and duty as the Plan sponsor, administrator, and named fiduciary.

## **THE BLUECARD PROGRAM AND MULTIPLAN**

### **I. THE BLUECARD PROGRAM**

56. During the time relevant to this suit, Blue Cross Blue Shield Association (**Association**) was owned in part by Defendant, its corporate parent, or both. Over thirty other entities—generally referred to as “Blues” because they use the Blue Cross Blue Shield branding—share ownership in the Association. The Blues, including Defendant

and/or its parent, operate the Association primarily as the licensor and owner of Blue Cross Blue Shield branding. The Blues fund the Association in various ways.

57. One way the Blues fund the Association—and thus, increase the value of their respective ownership interests in the Association—is through the BlueCard program. The BlueCard program also provides a way for Blues to bolster their revenue directly by overcharging self-funded health plans.

58. Throughout the relevant period, the thirty-plus Blues that own the Association assigned themselves geographic service areas free of competition from other Blues. Each Blue then, directly or through subsidiary Blues, created a provider network in their respective service areas. By default, members of a health plan administered by Defendant would be “out of network” if they sought medical treatment outside of Defendant’s specific geographic area. In theory, such out-of-network treatment would cost Plaintiff and Plan participants and beneficiaries more than in-network treatment with providers who have a discount arrangement with Defendant. In reality, a different Blue controls that territory, has discount arrangements with providers already in place, and extracts exorbitant fees from Defendant’s administered plans.

59. According to Defendant, Owens & Minor employees residing and working outside Defendant’s service area could access coverage near their respective residences and work locations even though they lived in another Blue’s service area and were, thus, outside Defendant’s network of providers. According to Defendant, Plaintiff and those employees would effectively enjoy in-network status through the BlueCard program so long as they remained in the network of the “host Blue” where they lived or worked.

According to Defendant, the BlueCard program would eliminate excess “out-of-network” costs of healthcare for Plaintiff’s remote employees and plan members. According to Defendant and BlueCard marketing efforts, Plaintiff would save money because it and Plan participants and beneficiaries receive the discounts negotiated between host Blues and their in-network providers.

60. Several BlueCard pamphlets use the following hypothetical to explain how BlueCard works:

Suppose you are an employer who provides coverage to your employees through Blue Cross Blue Shield of Tennessee. One of your out-of-state employees, Tom, sustains an injury while working in Illinois and immediately seeks medical attention from an Illinois Blue Card provider. After rendering the necessary medical services, the Illinois provider files a claim with Blue Cross and Blue Shield of Illinois, who in turn forwards the claim to Blue Cross Blue Shield of Tennessee. Under the Blue Card program, Tom’s “home” Plan—Blue Cross Blue Shield of Tennessee—then reimburses the Illinois provider at a rate typically based on the provider’s contract with the “host” Plan—Blue Cross Blue Shield of Illinois.

61. Relevant to this case, the “home” Blue is Defendant, and the “host” Blues are those who control the service areas where Plaintiff’s non-Virginia members and employees reside and work.<sup>18</sup> The Association manages the BlueCard program for self-

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<sup>18</sup> The BlueCard program also applies to Plan members who may reside and typically work in Defendant’s network but seek medical care in a host Blue’s network while traveling.

funded plans including Plaintiff by (i) overseeing these inter-service-area claims; (ii) governing and monitoring fees chargeable by host Blues under the license agreements; (iii) setting claims procedures; and (iv) providing phone and online support for Plan members utilizing BlueCard. The Association therefore provides a service to Plaintiff—an overpriced service—but a service nonetheless.

62. The Association and the Blues that own it devised the BlueCard program to increase Blues’ revenue in part through hidden fees that they would retain, distribute among the Blues, and pay to the Association. The Association requires all Blues to participate in the BlueCard program. So, in essence the *Blues* require the *Blues* to participate in the BlueCard program. The Blues serve the Association and themselves by extracting excessive fees from self-funded health plans across the country. This is a choice the Blues make—not something imposed by an unrelated third party. And because of the mandatory nature of the BlueCard program, the Association requires self-funded plans employing a Blue as a TPA to participate in the BlueCard program.

63. Defendant granted host Blues complete discretion with respect to the fees they charge for each BlueCard claim by Plan members. For instance, Defendant permitted host Blues to charge the Plan more than the providers even billed for the treatment or prescription. Defendant permitted host Blues to charge the Plan excessive fees, including a “network access fee”—at the host Blue’s discretion—up to \$2,000 per claim. A reasonable fiduciary in Defendant’s position—acting in the Plan’s best interest and not in the best interest of other Blues—would have mitigated these costs to Plaintiff by, among other things, negotiating these fees to be a small fraction of what they are or eliminated

them altogether. A reasonable fiduciary would not have granted host Blues such broad discretion in what to charge the Plan for BlueCard claims. Defendant's conduct reveals its true loyalty lies with the Blues and their parent organization—not Plaintiff.

64. Portions of these excess payments made by Plaintiff and Plan members are then paid to the Association, retained by the respective host Blues, and paid back to Defendant, either directly or in the form of host Blues allowing Defendant to charge equally exorbitant fees to self-funded plans in those host Blues' service areas through the BlueCard program. In other words, Defendant increases its profits by charging Plaintiff exorbitant fees. And because the Blues coordinate their efforts by mutually permitting one another to charge plans in the "home" network exorbitant fees, they extract excessive fees from self-funded plans across the country in a way that serves the Blue collective and the Association.

65. Additionally, as noted above, operation of the BlueCard program results in Plaintiff paying more money for a claim than is actually paid to the provider. Rather than adjusting these claims and refunding the excess payments to Plaintiff, Defendant and the host Blues withhold these funds in a so-called "variance account" to be used on prospective claims. But this variance account merely provides a way for Defendant and its affiliates to profit from Plaintiff's overpayments for healthcare and to pocket those overpayments to the detriment of the Plan. For example, while this money is held, the host Blue retains any interest earned. And upon terminating its relationship with Defendant, this money is not refunded to Plaintiff. Instead, host Blues and Defendant distribute these overpayments to themselves. No reasonable, loyal TPA or fiduciary with Plaintiff's best interests in mind would overcharge Plaintiff for services—or authorize others to overcharge—in order to

profit from those overcharges or permit its affiliates to profit from overcharges. By the very nature of this practice, Defendant creates a conflict of interest whereby it is given two choices: (i) serve Plaintiff's best interests and work as a reasonably prudent TPA and fiduciary by minimizing costs to the Plan or (ii) *overcharge* Plaintiff so Defendant and its affiliates can profit from the return on those overpayments and pocket the principal should Plaintiff terminate Defendant. Unfortunately, Defendant chose option (ii). Defendant has defended this misconduct by pointing to contractual provisions. In essence, Defendant has argued Plaintiff has waived any complaint to this practice by contract. But that contractual provision further demonstrates that Defendant has carried out that misconduct in performing its fiduciary services for Plaintiff. **Ex. A** at 50 (providing that host Blues may overcharge for services and retain those overages forever). With respect to Plaintiff's claims under ERISA, this contractual waiver argument fails. Defendant overpaid for BlueCard claims Plaintiff's assets and the balance of overpayments were kept in variance accounts. And because Plaintiff terminated Defendant, Defendant and its affiliates made returns on that money and failed to return that money to Plaintiff in violation of Defendant's fiduciary duties.

## **II. MULTIPLAN (AND OTHER OUT-OF-NETWORK CLAIM PROCESSING VENDORS)**

66. When a Plan member goes out-of-network for healthcare services, Defendant engages a third-party vendor, generally MultiPlan, to negotiate discounts and a payment amount with the providers. For simply engaging a vendor to negotiate with these out-of-network providers, Defendant charges Plaintiff unreasonable fees, which can reach



50% of the difference between the amount billed and the amount determined to be Plaintiff's responsibility (either the negotiated amount or, if negotiations are not successful, an amount determined by a pricing tool approved by Defendant). A fiduciary in Defendant's position must act in the principal's best interests—not its own. But rather than mitigate these costs to the Plan, Defendant uses outside vendors, such as MultiPlan, as a mechanism to divert Plaintiff's money to itself.

67. Defendant's conduct results in Defendant pocketing a windfall of exorbitant, unjustified fees at Plaintiff's expense. Rather than fulfill its fiduciary and other relevant duties to Plaintiff, Defendant enters into "confidential" contractual arrangements with vendors such as Multiplan so that Defendant can take money from Plaintiff while maintaining opacity.

### **PRIMARY MISCONDUCT SERVING AS THE BASIS OF THIS LAWSUIT**

68. Importantly, Defendant *expressly* agreed to serve as a fiduciary with respect to (i) "determin[ing] claims for benefits under the Plan"; (ii) "determin[ing] eligibility for benefits under the Plan"; (iii) "interpret[ing] the terms of the Plan"; and (iv) "perform[ing] its obligations and duties as expressed in [the ASA] . . . to the extent that its performance of such actions constitutes fiduciary action under ERISA." **Ex. A** at 4, art. 2.c. Defendant's misconduct falls within the broad scope of Defendant's express agreement to serve as a fiduciary. And given Defendant's possession and exercise of unfettered discretion and control over other relevant matters, Defendant was a functional fiduciary under ERISA with respect to carrying out the relevant misconduct alleged below. *Supra* ¶¶ 39 *et seq.* While the misconduct alleged in the following paragraphs and summarized in bold font

falls within the scope of this discretion and control—and therefore supports claims under ERISA—the misconduct alleged below also supports state-law claims alleged below.

69. **Causing Plaintiff to grossly overpay claims, including payments to certain providers exceeding 100% of charges actually billed by those providers:** As provided above, Defendant exercised full discretion with respect to (i) “determin[ing] claims for benefits under the Plan”; (ii) interpreting the terms of the Plan; (iii) determining how much Plaintiff would pay for claims; (iv) committing Plaintiff’s money to pay claims; and (v) identifying and recovering overpayments, including deciding whether and how to identify and recover overpayments. *Supra* ¶¶ 39, 41, 43, 45, 47, 50-52. Defendant’s unilateral decision to commit Plaintiff’s money to pay more than 100% of billed amounts to certain providers therefore falls within the scope of Defendant’s fiduciary role. While the number of claims to which this allegation applies renders it impracticable to identify each claim here, Plaintiff provides examples in **Ex. D**, attached hereto and filed under seal.

70. There is simply no good-faith basis for paying more on claims than a provider even sought to recover on a given claim. If a trustee sought to repair a plumbing defect in the trust beneficiary’s home and paid the plumber \$1,000 *more* than the plumber’s invoice, there would simply be no reasonable excuse for this waste and abuse of trust assets. Likewise, Defendant cannot reasonably justify paying more than a provider even charged using Plaintiff’s money. Defendant has no reasonable excuse for this practice. Certainly, Plaintiff obtained no benefit from this practice. To the contrary, Defendant overpaid certain providers on claims because (i) those providers had agreed to pay kickbacks to Defendant or to its affiliates, (ii) such overpayments increased the profit margin for Defendant and its

affiliates, and (iii) such providers agreed to take less in payments for services rendered under Defendant's and its affiliates' fully insured plans. Alternatively, these failures are the result of Defendant's failure to reasonably monitor claims for overpayment of such claims. These failures stemmed from neglect and lack of care driven by Defendant's desire to avoid spending money to monitor those claims, Defendant's refusal to manage the Plan according to levels of prudence and skill reasonably employed by TPAs and plan fiduciaries, and in Plaintiff's best interests. Defendant unreasonably failed or refused to uphold its duty to work in good faith to defray expenses of administering the Plan. Indeed, a reasonable fiduciary or TPA in Defendant's position and working to serve the Plan's interests would have more closely monitored the claims for this type of overpayment and would have recouped such overpayments for Plaintiff.

71. **Causing Plaintiff to pay for the same medical claims or identical services multiple times:** Defendant enjoyed unfettered discretion to (i) "determine claims for benefits under the Plan"; (ii) determine the scope of benefits due to participants and beneficiaries; (iii) necessarily determine the number of units of care for which Plaintiff would pay; (iv) determine the methodology used to calculate the amount Plaintiff would pay for claims; and (v) identify and recover overpayments and to re-adjudicate claims. *Supra* ¶¶ 39, 41, 50-52. Thus, this alleged misconduct falls within the scope of Defendant's fiduciary duty. While the number of claims that apply to this allegation are too voluminous to identify in detail here, Plaintiff provides examples in **Ex. D**, attached hereto and filed under seal.

72. This practice could only injure Plaintiff. There is no reasonable justification for this practice or argument that this benefited Plaintiff or Plan administration. Given the data and information Defendant possessed—which it concealed from Plaintiff—Defendant could easily have identified these overpaid claims. However, Defendant knew that properly monitoring claims for these defects would decrease its profit margin. Despite owing a duty to Plaintiff, Defendant did not care about these overpaid claims because it used Plaintiff’s money to pay those claims—not its own money. Alternatively, these failures are the result of Defendant’s failure or conscious refusal to manage the Plan according to levels of prudence and skill reasonably employed by TPAs and plan fiduciaries, and from failing to serve Plaintiff’s best interests—including without limitation working to decrease expenses of administering the Plan. Indeed, a reasonable fiduciary or TPA in Defendant’s position—working to serve Plaintiff’s interests—would have more closely monitored the claims for this type of overpayment and would have prevented or recovered such overpayments for Plaintiff. Defendant, however, did not.

73. **Improperly classifying affordable generic drugs as specialty pharmaceuticals, which resulted in Plaintiff paying excessive prices—or receiving less return in discounts and rebates—for generic drugs prescribed to Plan participants and beneficiaries, and paid by Plaintiff:** Defendant possessed and exercised full, unfettered discretion to (i) “determine claims for benefits under the Plan”; (ii) interpret the terms of the Plan; (iii) determine how much Plaintiff would pay for claims, including prescription claims; (iv) unilaterally commit Plaintiff’s money to claims; and (v) identify and recover overpayments for claims, including prescription claims. *Supra* ¶¶ 39, 40, 43,

45, 47, 50-52. Determining whether a drug is covered by the Plan and how much of Plaintiff's money to commit to paying for a prescription claim necessarily involves discretion with respect to classifying drugs as expensive specialty drugs or as inexpensive generic, non-specialty drugs. *See Ex. A* at 41 (definition of "specialty"). Thus, this allegation of misconduct falls within the scope of Defendant's fiduciary duty.

74. "Specialty drugs" are exponentially more expensive than generic drugs. While a generic drug may technically qualify as "specialty," as the ASA makes clear, there must be something "special" about those drugs, such as requiring "special handling, storage, and shipping requirements." *Ex. A* at 41. However, on numerous claims, Defendant paid exponentially more for generic drugs with Plaintiff's money that did not qualify as a specialty drug. In other words, the only thing "special" about those generic drugs was the price Defendant paid for the drug with Plaintiff's money. For instance, imatinib is a generic cancer growth blocker that can easily be obtained for approximately \$50 per prescription or less.<sup>19</sup> Using Plaintiff's money, Defendant paid exponentially more for imatinib prescriptions even though imatinib did not in any way qualify as a specialty drug for those prescriptions. There is a reason Defendant does this: payments go to PBMs that are Defendant's sister companies and affiliates. While this relationship is disclosed in certain agreements, Defendant and/or its affiliates unfairly profited from the built-in conflict of interest because Defendant permitted its affiliate PBMs to charge Plaintiff sometimes thousands of dollars for otherwise cheap generic drugs improperly

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<sup>19</sup> <https://www.costplusdrugs.com/medications/imatinib-400mg-tablet/>, last visited Feb. 6, 2025.

characterized as “specialty” given they do not fit any definition of specialty drug. Plan data that Plaintiff has been able to review to date show that Anthem caused the Plan to pay tens of thousands of dollars more for imatinib prescriptions than the NADAC value for these same prescriptions.<sup>20</sup> This is just one example.

75. Even setting aside the classification issue, Defendant overcharged for generic prescriptions. Given the breadth of claims that Defendant’s misconduct affected and the impracticability of identifying all such claims in this Complaint, Plaintiff offers examples in **Ex. D**, attached hereto and filed under seal. These are just examples of numerous claims whereby Defendant, using Plaintiff’s money, paid its pharmacies exponentially more for prescriptions than the price paid by the pharmacies. Given the maximum markup for prescription drugs generally does not exceed 20% and considering the average wholesale price pharmacies pay for these drugs, Defendant habitually paid exponentially more for drug claims with Plaintiff’s money than a fiduciary or TPA exercising the care, skill, prudence, and diligence of a reasonably prudent fiduciary or TPA would have. Even more, Defendant overpaid prescription claims with Plaintiff’s money because Defendant’s arrangements with its PBM and network pharmacies (i) allowed Defendant to be paid kickbacks from those overpayments; (ii) allowed for Defendant’s network providers to be overpaid by Plaintiff in exchange for more favorable arrangements for Defendant in its fully insured segment; and (iii) allowed for Defendant-affiliated PBMs to receive excessive

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<sup>20</sup> “NADAC” refers to the national average drug acquisition cost, which was jointly developed by the Centers for Medicare and Medicaid Services and calculates the average price that pharmacies pay for prescription drug. This sum refers to the *average* cost that prescription retailers in the U.S. pay for the drug at issue for the time relevant to the claim.

payment for these drugs. Defendant and its affiliates therefore profited from its practice of overpaying prescription claims with Plaintiff's money. Alternatively, these failures are the result of Defendant's failure to manage and administer the Plan and its assets according to levels of prudence and skill reasonably employed by TPAs and plan fiduciaries, and in Plaintiff's best interests—including without limitation working to decrease expenses of administering the Plan. Indeed, a reasonable fiduciary or TPA in Defendant's position and working to serve Plaintiff's interests would have more closely monitored the claims for this type of overpayment and would have prevented and recovered such overpayments for the Plan or worked with providers and the PBM to eliminate the excess charges.

76. **Withholding pharmaceutical rebates from Plaintiff, thereby reducing Plaintiff's assets and effectively causing overpayment of claims:** Defendant enjoyed unfettered discretion and control over (i) "determin[ing] claims for benefits under the Plan"; (ii) determining how much Plaintiff would pay for claims, including prescription claims; (iii) committing Plaintiff's money to pay claims; (iv) creating and using relationships with others (including prescription intermediaries and PBMs who obtain rebates and discounts) to control, manage, and administer the Plan and Plaintiff's expenditures; and (v) recovery of overpayments by Plaintiff. *Supra* ¶¶ 39, 40, 43, 45, 47. 50-52, **Ex. A** at 12, art. 14.a.1. This misconduct therefore falls within the scope of Defendant's fiduciary duty.

77. Consistent with its fiduciary duty, Defendant agreed to pay 100% of drug rebates generated by Plan claims. *See, e.g., Ex. A* at 19. Further, because the Plan's prescription claims generated those rebates, Defendant would have paid 100% of the drug

rebates to Plaintiff had it acted as a reasonable fiduciary or TPA or as a fiduciary or TPA attempting in good faith to defray the Plan’s healthcare costs. Defendant improperly retained a portion of drug rebates generated by the Plan and permitted its affiliated PBMs to retain a portion of these rebates. Defendant then falsely reported to Plaintiff that Plaintiff received all rebates. In doing so, Defendant breached the ASA; placed its own interests above Plaintiff’s; failed to act with reasonable care, prudence and diligence given the circumstances; and failed to act for the exclusive purpose of serving Plaintiff, including limiting the expenses of administering the Plan. Indeed, a reasonably prudent and loyal TPA in Defendant’s position would have passed on 100% of drug rebates to Plaintiff.

78. **Using Plaintiff’s funds to pay more for prescriptions than charged by providers—a practice called “spread pricing”—which caused Plaintiff to pay significantly more for prescription drugs while allowing Defendant or its affiliates to retain the excess:** Defendant possessed and exercised full, unfettered discretion to (i) “determine claims for benefits under the Plan”; (ii) interpret the terms of the Plan; (iii) determine how much Plaintiff would pay for claims, including prescription claims; (iv) determine whether and how to monitor for overpayments and whether and how to recover overpayments; (v) commit Plaintiff’s money to pay claims; and (vi) determine the methodology used to identify amounts it would pay for claims with Plaintiff’s money. *Supra* ¶¶ 39, 40, 41, 45, 47, 50-52. This allegation therefore falls within the scope of Defendant’s fiduciary duty.

79. “Spread pricing” in this context refers to Defendant’s practice of paying more for prescription claims with Plaintiff’s money than what was paid to the provider.



Defendant does not provide pass-through pricing, which is reasonably feasible and would benefit Plaintiff by limiting cost of claims. Defendant does not even monitor the percentage of Plaintiff's money that goes to the cost of the prescriptions as opposed to the fees imposed by Defendant's affiliates that it permits to unnecessarily serve as intermediaries. As a result, these intermediaries, including Defendant's affiliates serving as PBMs, unreasonably inflated prescription claims with undisclosed, excessive fees to Plaintiff's detriment. There is no reasonable argument that spending more of Plaintiff's money for prescription claims than was paid to providers was for Plaintiff's benefit. Moreover, the amount of the spread retained by Defendant and its affiliated intermediaries was excessive. Even assuming pass-through pricing were not feasible, a reasonably prudent and loyal TPA or fiduciary working to defray costs and in Defendant's position would have (i) arranged for the Plaintiff to pay a transparent, per-claim fee to the PBM or other intermediaries instead of permitting its affiliated PBM and intermediaries to charge hidden, concealed, excessive, and fluctuating fees on a per-claim basis; (ii) refrained from collecting portions of those spread pricing excesses for its own benefit and to Plaintiff's detriment; and (iii) reported the amount of spread pricing excesses generated by the Plan's prescription claims. Defendant did none of this.

**80. Steering, requiring, or otherwise encouraging Plan participants and beneficiaries to use Defendant-affiliated providers and intermediaries who charged more for the same or lesser quality of care and who passed on the excess of these payments to Defendant or its affiliated companies:** Defendant enjoyed unfettered discretion to (i) "determine claims for benefits under the Plan"; (ii) interpret the terms of

the Plan; (iii) determine the scope of benefits; (iv) determine the methodology used to calculate amounts Defendant would pay on claims with Plaintiff's money; and (v) determine whether and how to identify and recover overpayments by Defendant with Plaintiff's money. *Supra* ¶¶ 39, 41, 42, 50-52. By channeling Plan participants and beneficiaries to particular providers who Defendant knew would overcharge Plaintiff because of their relationship with Defendant, Defendant violated its fiduciary duty by abusing the trust and discretion it had with respect to the Plan and Plaintiff's assets.

81. One way Defendant perpetrated this misconduct was by naming its affiliates as PBMs, who charged Plaintiff more for prescriptions than competitors and who retained rebates that rightfully belong to Plaintiff. Defendant therefore steered *every* prescription claim through its affiliated PBMs, which overcharged for prescriptions, withheld rebates, and engaged in deceptive spread pricing as alleged above. Another way Defendant carried out this misconduct was by punishing Plaintiff if it failed to designate Defendant and its affiliates as exclusive specialty drug providers. *See Ex. A* at 40. Thus, Defendant steered all the Plan's specialty drug prescription claims to itself, and as provided above, it abused this role by improperly deeming everyday generics as "specialty" drugs in order to charge Plaintiff exponentially more than those drugs would otherwise cost. Moreover, Defendant advertises on behalf of its affiliated providers and others willing to give something in return to Defendant (such as better discounts for Defendant's fully insured segment and kickbacks) to participants and their beneficiaries but not for providers that are not affiliated with Defendant or who are unwilling to give something in return. Those providers charge

Plaintiff more than what other similarly situated and capable providers would charge for the same service.

82. **Knowingly or negligently engaging intermediaries between Defendant and providers who required payment well in excess of providers' charges and pocketing the difference paid by Plaintiff:** Defendant exercised full discretion (i) to “determine claims for benefits under the Plan”; (ii) interpret the terms of the Plan; (iii) to determine how much Plaintiff would pay for claims; (iv) determine whether and how to identify overpayments and whether and how to recover overpayments; and (v) commit Plaintiff’s money to pay claims. *Supra* ¶¶ 39, 40, 43, 45, 47, 50-52. This misconduct falls within the scope of Defendant’s fiduciary duty.

83. **Failing to meet discount and rebate guarantees for prescription drug claims and otherwise failing to secure reasonably available discounts and rebates for prescription drug claims:** Defendant possessed and exercised full, unfettered discretion to (i) “determine claims for benefits under the Plan”; (ii) interpret the terms of the plan; (iii) determine how much Plaintiff would pay each claim; (iv) unilaterally commit Plaintiff’s money to claims; (v) determine the methodology used to determine the amount Plaintiff would pay for claims; and (vi) to determine whether and how to identify overpayments and whether and how to recover overpayments. *Supra* ¶¶ 39, 40, 41, 43, 45, 47, 50-52. This misconduct therefore falls within the scope of Defendant’s fiduciary duty.

84. Defendant failed to secure discounts and rebates reasonably available, guaranteed by the ASA, or both. Defendant’s failure to secure reasonable and/or agreed

upon discounts applies both to the aggregate of prescription claims and in the exemplar claims identified in **Ex. D**, attached to this Complaint and filed under seal.

85. To the extent Defendant relies on contract language to excuse its misconduct, Defendant likewise failed to meet those discount and rebate guarantees. *See Ex. A* at 40-41; *Ex. C* at 40-41. Perhaps the most egregious example was generic discounts, which were meant to exceed 82% at times to which this Complaint applies. The data made available to Plaintiff shows that Defendant failed to meet that standard.

86. **Paying for services not actually provided, which could have been detected with reasonable prudence and effort:** Defendant wielded unfettered discretion to (i) “determine claims for benefits under the Plan”; (ii) interpret the terms of the Plan; (iii) determine how much of Plaintiff’s money Defendant would commit to pay claims; and (iv) determine whether and how to identify such overpayments and whether and how to recover such overpayments. *Supra* ¶¶ 39, 40, 41, 45, 47. This misconduct therefore falls within the scope of Defendant’s fiduciary duty. No reasonable, loyal fiduciary or TPA in Defendant’s position would use Plaintiff’s money to pay claims for services or prescriptions not provided. With the information that Defendant possessed—and refused to share with Plaintiff—Defendant could have readily identified these claims and associated overpayments. Healthcare provider coders routinely enter service codes for services and treatment that were not actually provided. Likewise, providers routinely overcharge based on those errors. Defendant knows this given its vast experience in the industry. In its fully insured segment, Defendant has systems in place that identify these coding errors and either avoid or recover overpayments. But because the Plan is self-

funded, Defendant simply opts not to use these systems because its own money is not at risk and because those systems present a cost that would decrease Defendant's net revenue earned through its management and administration of the Plan. Defendant also knows that these improper claims can be identified by reviewing itemized bills and medical charts. Defendant failed to prevent, identify, or remedy these overpayments because (i) Defendant sought to protect its own bottom line by avoiding any added expense necessary to take such actions; (ii) Defendant benefits from such overpayments through kickbacks or more favorable arrangements with these providers in its fully insured segment; (iii) Defendant failed its duty to act with the care, skill, and diligence of a reasonably prudent TPA or fiduciary in similar circumstances. Through these failures, Plaintiff overpaid on numerous claims, and Plaintiff could not recover those overpayments from providers.

87. **Protecting its fully insured segment—where Defendant pays claims from its own assets—by securing less favorable discount arrangements with network providers for Plaintiff in exchange for more favorable discounts in Defendant's fully insured segment:** Defendant enjoyed absolute discretion in (i) “determin[ing] claims for benefits under the Plan”; (ii) interpreting the terms of the Plan; (iii) determining whether and how to identify overpayments and whether and how to recoup overpayments on behalf of Plaintiff; (iv) determining how much of Plaintiff's money Defendant would commit to pay specific claims; and (v) designating in-network healthcare providers for the Plan, including the terms that would govern the relationship between the Plan and in-network providers and the amounts Plaintiff would pay those providers for healthcare. *Supra* ¶¶ 39,

40, 41, 42, 43, 45, 47, 50-52. Defendant's misconduct therefore falls within the scope of its fiduciary role.

88. With respect to Defendant's fully insured plans, Defendant partially bears the risk that amounts paid for total claims will exceed Defendant's expectations because Defendant is responsible for paying claims with its own money less premiums paid by insureds. But because the Plan is self-funded, Defendant bears no risk because it pays claims with Plaintiff's money. Disregarding its various duties to Plaintiff, Defendant arranged for Plaintiff to pay Defendant's network providers more for claims from the Plan's self-funded coffers than Defendant agreed to pay the same network providers for identical services under Defendant's fully insured plans. By intentionally or negligently failing to secure reasonably available and favorable rates for Plaintiff, Defendant failed to act as a fiduciary or TPA exercising the care, skill, prudence, and diligence that a reasonably prudent fiduciary or TPA would have. Even more, through this practice, Defendant enhanced its profits in its fully insured segment because its network providers agreed to more favorable discount arrangements merely as a quid pro quo for Defendant committing Plaintiff to pay its network providers more with Plaintiff's money. Defendant appears primed to argue that because it harms all self-funded plans it manages through this practice, this is just a "business practice" that cannot support an ERISA claim. But ERISA does not forgive unlawful conduct simply because a fiduciary commits that misconduct as part of a core business strategy. Defendant placed its own interests above Plaintiff's by paying more to providers with Plaintiff's money than it reasonably needed to in order to secure more favorable network arrangements in its fully insured segment. This misconduct

further demonstrates that Defendant could have secured much more favorable discounts for Plaintiff but simply chose not to or negligently failed to. A loyal, reasonably prudent fiduciary or TPA in Defendant’s position would have secured better discounts for Plaintiff and at least matched what Defendant achieved for itself in fully insured plans. As a result of this negligent, self-serving conduct, Plaintiff paid more on claims than it should have, and Defendant profited from this injury to Plaintiff.

89. **Improperly paying claims for outpatient services for inpatient patients that should not have been billed because those billed outpatient services were paid as part of inpatient services:** Defendant had unfettered control and discretion over (i) “determin[ing] claims for benefits under the Plan”; (ii) interpreting the terms of the Plan; (iii) determining how much Plaintiff would pay for claims; (iv) determining eligibility for benefits and scope of benefits; (v) determining whether and how to review claims for coding errors and overpayment and whether and how to recover overpayments; and (vi) determining the methodology for calculating the amount of Plaintiff’s money Defendant would commit and use to pay claims. *Supra* ¶¶ 39, 40, 41, 45, 46, 47, 43, 50-52. Defendant’s misconduct therefore falls within the scope of its fiduciary duty. In **Ex. D**, attached hereto and filed under seal, Plaintiff offers a few examples of outpatient claims that Defendant caused Plaintiff to pay while the patient was inpatient at a medical facility.

90. General billing and coding guidelines and principles prohibit the practice of charging for outpatient services for inpatient patients. Standards governing ERISA fiduciaries and TPAs prohibit them from paying such miscoded bills and claims with plan money—especially when the coding errors increase the plan’s cost as is the case here. But

Defendant paid such claims with Plaintiff's money, improperly charging Plaintiff for outpatient services rendered to inpatient patients. By paying for outpatient services rendered to inpatient patients, Defendant overpaid with Plaintiff's money because those claims would have been less had they been billed and adjudicated as inpatient only. Defendant's payment of such claims and failure to monitor the bills to avoid these overpayments fell short of what a reasonably prudent and loyal fiduciary or TPA would do. A reasonably prudent and loyal fiduciary or TPA in similar circumstances would monitor claims for these errors, identify those errors, and recover overpayments. A reasonably prudent and loyal fiduciary or TPA would report to Plaintiff the number of nonconforming claims and the amounts of overpayments. Defendant did none of this. Moreover, Defendant simply paid these claims with Plaintiff's money because Defendant put its own interests above Plaintiff's; had Defendant spent the resources to monitor these claims and correct them, Defendant's profit margin would fall with respect to its work for Plaintiff. Thus, Defendant did not attempt to monitor or correct these claims or recover these overpayments. Defendant also refrained from correcting or remedying this problem to protect its favorable relationship with providers in its fully insured segment; forcing providers to correct their bills or refund overpayments to Plaintiff would sour Defendant's relationship with providers. Thus, Defendant ignored and concealed these known overpayments to protect its bottom line to Plaintiff's detriment.

**91. Paying claims that were coded incorrectly or which violated internal or external billing and coding rules or guidelines despite the fact that Defendant either knew those claims were coded incorrectly or would have known had it exercised**



**reasonable care and placed Plaintiff's interest above its own:** Defendant had unfettered control and discretion over (i) “determin[ing] claims for benefits under the Plan”; (ii) interpreting the terms of the Plan; (iii) determining how much Plaintiff would pay for claims; (iv) determining eligibility for benefits and scope of benefits; (v) determining whether and how to review claims for coding errors and overpayment and whether and how to recover overpayments; and (vi) determining the methodology for calculating the amount of Plaintiff's money Defendant would commit and use to pay claims *Supra* ¶¶ 39, 40, 41, 45, 46, 47, 43, 50-52. Defendant's misconduct therefore falls within the scope of its fiduciary duty.

92. Defendant caused the Plan to pay numerous claims that violated coding and billing rules and guidelines, including National Correct Coding Initiative (NCCI<sup>21</sup>) rules and edits, and even Defendant's *own* rules and guidelines such as those set forth in Defendant's published medical policies, clinical guidelines, and provider manuals. Similarly, Defendant caused the Plan to pay provider services at amounts greater than the negotiated rates published in accordance with the Transparency in Coverage regulation. Given the volume of claims that fit this description, it is impracticable to identify them all. Plaintiff therefore provides the examples in **Ex. D**, attached hereto and filed under seal.

93. A reasonable fiduciary or TPA in Defendant's position and exercising total control over the amount it pays for claims with Plaintiff's money would require bills paid

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<sup>21</sup> NCCI is a program developed by the Centers for Medicare & Medicaid Services (CMS) to publish rules and guidelines to promote correct coding methodologies and control improper coding that leads to inappropriate payment in medical claims.

by Plaintiff to satisfy applicable coding and billing rules and standards, and would certainly not cause Plaintiff to pay providers for services at rates that exceeded Defendant's own negotiated rates with those providers, published in accordance with Transparency in Coverage regulations. Defendant paid claims with Plaintiff's money that were supported by improperly coded bills, which violated coding and billing rules and guidelines (including those published by NCCI and Defendant itself), or which exceeded the published negotiated rates between Defendant and providers. Specifically, by paying bills that violated internal and external billing and coding rules, or which exceeded Defendant's negotiated rates, Defendant increased the amount of Plaintiff's money that was used to pay such claims. Defendant's payment of such claims and failure to monitor the bills to avoid these overpayments fell short of what a reasonably prudent and loyal fiduciary or TPA would do. Moreover, Defendant simply paid these claims with Plaintiff's money, because Defendant put its own interests above Plaintiff's; had Defendant spent the resources to monitor these claims and correct them or refuse to pay them, Defendant's profit margin would fall with respect to its work for Plaintiff. Further, Defendant ignored these coding errors by its network providers in order to protect more favorable relationships with those providers in Defendant's fully insured segment.

94. **Paying for multiple units of specific treatments in a given day when applicable coding rules and standards (such as NCCI rules and edits) prohibited multiple units in a given day:** Defendant had unfettered control and discretion over (i) "determin[ing] claims for benefits under the Plan"; (ii) interpreting the terms of the Plan; (iii) determining how much of Plaintiff's money Defendant would commit to pay for

claims; (iv) determining eligibility for benefits and scope of benefits; (v) determining whether and how to review claims for coding errors and overpayment and whether and how to recover overpayments; (vi) determining the methodology for calculating the amount of Plaintiff's money Defendant would commit and use to pay claims. *Supra* ¶¶ 39, 40, 41, 45, 46, 47, 43, 50-52. Defendant's misconduct therefore falls within the scope of its fiduciary duty. The number of claims supporting this allegation are too voluminous to include an explanation of each claim in this Complaint. Thus, Plaintiff offers the following examples of instances where Defendant used Plan funds to pay for multiple units of specific treatments in a single day despite generally accepted coding rules that prohibit multiple units in a single day. Plaintiffs provide examples in **Ex. D**, attached to this Complaint and filed under seal.

95. Generally applicable coding standards (including NCCI rules and edits) limit the units of certain healthcare that may be billed in a given day or other period of time. A common example is physical therapy. Nevertheless, Defendant used Plaintiff's money to pay for multi-unit healthcare, which applicable coding standards prohibit in certain circumstances. Defendant's payment of such claims and/or its failure to monitor the invoices to avoid these overpayments fell short of what a reasonably prudent and loyal fiduciary or TPA would do. Moreover, Defendant simply paid these claims with Plaintiff's money, because Defendant put its own interests above Plaintiff's; had Defendant spent the resources to monitor these claims and correct them or refuse to pay them, Defendant's profit margin would fall with respect to its services for Plaintiff. A reasonably prudent and loyal fiduciary or TPA would have monitored claims for such overpayment and would have

refused to over-pay and recovered the excess payments caused by these easily identified excess bills. Defendant, while concealing the data and materials necessary to identify these errors from Plaintiff, could have readily and reasonably identified these errors and overpayments using claims data and information. Further, Defendant ignored these coding errors by its network providers in order to protect more favorable relationships with those providers in Defendant's fully insured segment.

96. **Paying hospice charges beyond the acceptable timeframe without recertification:** Defendant had unfettered control and discretion over (i) "determin[ing] claims for benefits under the Plan"; (ii) interpreting the terms of the Plan; (iii) determining how much Plaintiff would pay for claims; (iv) determining eligibility for benefits and scope of benefits; (v) determining whether and how to review claims for coding errors and overpayment and whether and how to recover overpayments; and (vi) determining the methodology for calculating the amount of Plaintiff's money Defendant would commit and use to pay claims. *Supra* ¶¶ 39, 40, 41, 45, 46, 47, 43, 50-52. Defendant's misconduct therefore falls within the scope of its fiduciary duty.

97. Medicare rules incorporated by the Plan and generally applicable industry standards required that patients approved for hospice care be recertified after being on hospice care for six months. This is because hospice care is generally available only for patients who suffer from a condition reasonably limiting life expectancy to within six months. With Plaintiff's money, Defendant paid hospice claims that were for hospice care extending beyond six months without the recertification that applicable standards require. Defendant's payment of such claims and failure to monitor the invoices to avoid these

overpayments fell short of what a reasonably prudent fiduciary or TPA would do. Moreover, Defendant simply paid these claims with Plaintiff's money because Defendant put its own interests above Plaintiff's; had Defendant spent the resources to monitor these claims and correct them or refuse to pay them, Defendant's profit margin would fall with respect to its work for Plaintiff. A reasonably prudent and loyal fiduciary or TPA would have monitored claims for such overpayment and failure to recertify and would have prevented and recovered the excess payments caused by these easily identified coding errors. Indeed, Defendant, while concealing the data and materials necessary to identify these errors from Plaintiff, could have readily identified these errors and overpayments using claims data and information. Further, Defendant ignored these coding errors by its network providers vis-à-vis Plaintiff's plan in order to protect more favorable relationships with those providers in Defendant's fully insured segment.

98. **Through the BlueCard program, with actual or constructive knowledge, transferring Plaintiff's assets to parties in interest, various host Blues and the Association,<sup>22</sup> in the form of overpayments for fees and services,<sup>23</sup> the withholding of Plaintiff's assets in "variance accounts," and the failure to return those assets to Plaintiff:** Defendant had unfettered discretion to (i) "determine claims for benefits under the Plan"; (ii) interpret the terms of the Plan; (iii) take control of Plaintiff's money and

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<sup>22</sup> A "party in interest" includes entities "providing services" to the Plan. 29 U.S.C. § 1002(14)(B). As alleged above, various host Blues and the Association provided services to Plaintiff through the BlueCard program.

<sup>23</sup> While ERISA permits Defendant to use Plan assets to pay for services necessary for the operation of the Plan, that compensation must be "reasonable" in order to trigger that exemption. *See* 29 U.S.C. § 1108(b)(2).

commit it to payments of claims; (iv) determine whether and how to identify and recoup overpayments; and (v) determine the methodology used to calculate the amount Defendant would pay a claim with Plaintiff's money. *Supra* ¶¶ 39, 40, 41, 43, 45, 50-52. This misconduct therefore falls within the scope of Defendant's fiduciary role. Plaintiff has alleged the relevant misconduct above. *Supra* ¶¶ 56-65.

99. **Through arrangements with MultiPlan and similar vendors as alleged above, causing Plaintiff to pay exorbitant, unreasonable fees to Defendant and vendors:** Defendant had unfettered discretion to (i) "determine claims for benefits under the Plan"; (ii) interpret the terms of the Plan; (iii) take control of Plaintiff's money and commit it to payment of claims; (iv) determine whether and how to identify and recover overpayments; and (v) determine the methodology used to calculate amounts Defendant would pay on each claim with Plaintiff's money, including out-of-network claims that involved MultiPlan and other vendors Defendant involved in its processing of out-of-network claims. *Supra* ¶¶ 39, 40, 41, 43, 45, 48, 50-52. This misconduct therefore falls within the scope of Defendant's fiduciary role. Defendant has alleged relevant misconduct above. *Supra* ¶¶ 66-67. Defendant engaged MultiPlan to negotiate discounts on medical claims from providers outside of Defendant's network. First, Defendant did not reasonably need to employ MultiPlan or other vendor to manage, administer, price, or adjudicate out-of-network claims. Thus, the portion of discounts retained by MultiPlan and other vendors on out-of-network claims was excessive. Second, Defendant—despite not doing any of this work and despite paying MultiPlan far less to secure these discounts—retained 50% of the discounts instead of passing those discounts to Plaintiff. MultiPlan charges approximately

5% of the discount as its fee on out-of-network claims. Thus, as a fiduciary and TPA not investing any effort or time in achieving these discounts, Defendant retained approximately 45% of the discount to the exclusion of Plaintiff. As a result, Plaintiff paid more on out-of-network claims than it should because Defendant pocketed an excessive proportion of the discount. A reasonably prudent and loyal fiduciary or TPA would have passed the total discounts to Plaintiff or, alternatively, far more than 50%. But Defendant saw this as an opportunity to receive exorbitant fees from Plaintiff on a per-claim basis for doing absolutely nothing.

100. **Failing to inform Plaintiff of these actions and the costs these actions imposed on Plaintiff when doing so reduced Plaintiff's assets while enriching Defendant and its affiliated companies:** In addition to its fiduciary duty in connection with assets, determining benefits, and interpreting the terms of the plan, *e.g. supra* ¶¶ 39, 40, 45, 47, 50-52, Defendant also exercised absolute control over the information necessary for Plaintiff to identify Defendant's misconduct. *See, e.g., Ex. A* at 10-11, art. 11.a, 11.b, 11.d, 12.d. Far from honoring its obligations of transparency and candor, for years, Defendant concealed the claims data from Plaintiff because it demonstrates (i) Defendant spends more of Plaintiff's money for medical and prescription claims than is reasonably necessary; (ii) Defendant knew Plaintiff would change to a different fiduciary/TPA if Plaintiff knew Defendant overspent Plaintiff's money on medical and prescription claims; and (iii) Defendant knew that so long as Plaintiff remained ignorant of Defendant's misconduct due to its concealment of its misconduct and withholding of claims data, Defendant would continue to receive kickbacks from providers and PBMs from those

overpayments, and would continue to enjoy inflated profits from its misconduct. Of course, Defendant concealed that information and its misconduct in order to prevent facing the legal, business, and reputational consequences of its misconduct.

### **JURISDICTION AND VENUE**

101. This is a fiduciary action brought by a plan fiduciary pursuant to ERISA. Thus, United States district courts enjoy subject matter jurisdiction over this dispute. 29 U.S.C. § 1132(e)(1); *see also* 28 U.S.C. § 1331 (federal question); *id.* § 1367 (supplemental jurisdiction).

102. Venue is proper in this district and division because the Plan is administered in Richmond, Virginia, the relevant breaches occurred in Richmond, Virginia, and Defendant is headquartered in Richmond, Virginia. 29 U.S.C. § 1132(e)(2); 28 U.S.C. § 1391(b); E.D. Va. Loc. Civ. R. 3(B)(4). Those same grounds support this Court’s exercise of personal jurisdiction over Defendant. Moreover, this case arises from Defendant’s misconduct in Virginia; from an agreement or agreements negotiated, executed, and performable in Virginia and that designate Virginia law as governing state law; and from Defendant’s contacts in Virginia which are described throughout this Complaint.

### **CAUSE OF ACTION FOR ERISA VIOLATIONS**

103. Plaintiff incorporates all other paragraphs in this Complaint as if fully restated here. Plaintiff specifically incorporates paragraphs alleging Defendant’s fiduciary status and misconduct. *Supra* ¶¶ 39-52, 68-100.

104. Under ERISA, Defendant is a Plan fiduciary as alleged above. *Supra* ¶¶ 39-52. Defendant expressly agreed to serve as a fiduciary with respect to (i) “determin[ing]



claims for benefits under the Plan”; (ii) “determin[ing] eligibility for benefits under the Plan”; (iii) “interpret[ing] the terms of the Plan”; and (iv) “perform[ing] its obligations and duties as expressed in [the ASA] . . . to the extent that its performance of such actions constitutes fiduciary action under ERISA.” **Ex. A** at 4, art. 2.c. And as alleged above, Defendant wielded and exercised total discretion and control over the management and administration of the Plan and its assets. *See, e.g., supra* ¶¶ 39, 40, 41, 43 45, 46, 47, 48, 50-52. The misconduct alleged in detail above, *supra* ¶¶ 68-100, and restated below falls within the broad scope of Defendant’s fiduciary duties.<sup>24</sup>

105. The Plan is an ERISA welfare benefit plan subject to the protections afforded by ERISA.

106. Plaintiff Owens & Minor is a Plan fiduciary and the Plan’s sponsor. Plaintiff Owens & Minor brings this claim on the Plan’s behalf in Plaintiff’s capacity as Plan sponsor and named fiduciary.

107. Under ERISA, Defendant must discharge its duties to the Plan solely in the interest of Plan participants and beneficiaries and “for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries[] and defraying reasonable expenses of administering the plan.” *See* 29 U.S.C. § 1104(a)(1). ERISA requires Defendant to discharge its duties with the “care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like

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<sup>24</sup> Note that paragraphs 68-100 connect the scope of Defendant’s fiduciary status to particular misconduct.

aims . . . and in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of [ERISA].” *Id.* § 1104(a)(2).

108. Further, ERISA prohibits a fiduciary from dealing with assets of the plan in the fiduciary’s “own interest or for [its] account.” 29 U.S.C. § 1106(b). ERISA also prohibits Defendant from causing the Plan to engage in a transaction if Defendant knows or should know that such transaction constitutes a direct or indirect transfer to, or use by or for the benefit of a party in interest, of any assets of the Plan. *Id.* § 1106(a)(1)(D).

109. Defendant has violated these duties as alleged above. *See supra* ¶¶ 68-100. Specifically, Defendant violated ERISA through the following misconduct:

- i. Causing the Plan to grossly overpay claims, including payments to certain providers exceeding 100% of charges actually billed by those providers, *supra* ¶¶ 69-70;
- ii. Causing the Plan to pay for the same medical claims or identical services multiple times, *supra* ¶¶ 71-72;
- iii. Improperly classifying affordable generic drugs as specialty pharmaceuticals, which resulted in the Plan paying excessive prices—or receiving less return in discounts and rebates—for generic drugs prescribed to Plan participants and beneficiaries, and paid by the Plan, *supra* ¶¶ 73-75;

- iv. Withholding pharmaceutical rebates from the Plan, thereby reducing the Plan’s assets and effectively causing overpayment of claims, *supra* ¶¶ 76-77;
- v. Using Plan funds to pay more for prescriptions than charged by providers—a practice called “spread pricing”—which caused the Plan to pay significantly more for prescription drugs while allowing Defendant or its affiliates to retain the excess, *supra* ¶¶ 78-79;
- vi. Steering, requiring, or otherwise encouraging Plan participants and beneficiaries to use Defendant-affiliated providers and intermediaries who charged more for the same or lesser quality of care and who passed on the excess of these payments to Defendant or its affiliated companies, *supra* ¶¶ 80-81;
- vii. Knowingly or negligently engaging intermediaries between Defendant and providers who required payment well in excess of providers’ charges and pocketing the difference paid by the Plan, *supra* ¶ 82;
- viii. Failing to meet discount and rebate guarantees for prescription drug claims and otherwise failing to secure reasonably available discounts and rebates for prescription drug claims, *supra* ¶ 83-85;
- ix. Paying for services not actually provided, which could have been detected with reasonable prudence and effort, *supra* ¶ 86;
- x. Protecting its fully insured segment—where Defendant pays claims from its own assets—by securing less favorable discount arrangements with

network providers for the Plan in exchange for more favorable discounts in Defendant's fully insured segment, *supra* ¶¶ 87-88;

- xi. Improperly paying claims for outpatient services for inpatient patients that should not have been billed because those billed outpatient services were paid as part of inpatient services, *supra* ¶¶ 89-90;
- xii. Paying claims that were coded incorrectly, which violated internal or external billing and coding rules and guidelines, or which exceeded Defendant's published negotiated rates with providers, despite the fact that Defendant either knew those claims were coded or billed incorrectly or would have known had it exercised reasonable care and placed the Plan's and its members' interests above its own, *supra* ¶¶ 91-93;
- xiii. Paying for multiple or excessive units of specific treatments in a given day (or other period of time) when applicable coding rules and standards prohibited multiple, or more than a certain number of, units in a given day (or period of time), *supra* ¶¶ 94-95;
- xiv. Paying hospice charges beyond the acceptable timeframe without recertification, *supra* ¶¶ 96-97;
- xv. Through the BlueCard program, with actual or constructive knowledge, transferring Plan assets to parties in interest, various host Blues and the Association, in the form of overpayments for fees and services, the withholding of Plan assets in "variance accounts," and the failure to return those assets to the Plan, *supra* ¶¶ 56-65, 98;

- xvi. Through arrangements with MultiPlan and similar vendors as alleged above, causing the Plan to pay exorbitant, unreasonable fees to Defendant and vendors, *supra* ¶ 99;
- xvii. Failing to inform the Plan or its plan sponsor of these actions and the costs these actions imposed on the Plan when doing so reduced Plan assets while enriching Defendant and its affiliated companies, *supra* ¶ 100.

110. With respect to prescription claims, Defendant's failure was extraordinary. For example, the Federal Supply Schedule publishes information on optimum returns on prescription costs that a TPA like Defendant can achieve in U.S. markets. Those optimum returns are approximately 26% according to that schedule. The U.S. Postal Service has published an audit of its own plan showing 29% returns to the plan for prescription costs. Through Defendant's failure to uphold its fiduciary duties, Plaintiff's Plan realized less than half of those returns on prescription claims.

111. Whether Defendant's failures stem from negligence, conscious disregard for the Plan's interests, breach of the ASA, or even an intent to harm the Plan and enrich itself and its affiliates, Defendant's misconduct violates the duties imposed by ERISA.

112. Defendant's self-dealing, neglect, and other misconduct has caused the Plan to lose at least tens of millions of dollars. Plaintiff expects its damage estimates to increase as it obtains and analyzes additional information through discovery. Defendant also improperly collected millions in ill-gotten gains from Plan funds.

### **STATE LAW CAUSES OF ACTION**<sup>25</sup>

113. To the extent ERISA does not preempt relevant state law claims, Plaintiff alleges the following state law causes of action.

#### **I. BREACH OF CONTRACT**

114. Plaintiff incorporates all other paragraphs in this Complaint as if fully restated here.

115. Plaintiff further incorporates **Exhibits A-D** as if fully restated here.

116. This claim is brought by Plaintiff Owens & Minor in its individual capacity and, alternatively, on behalf of the Plan.

117. Plaintiff and Defendant are parties to the ASA and its related schedules and amendments.

118. Defendant expressly agreed to serve as fiduciary with respect to the Plan's claims administration and payments either by expressly accepting "fiduciary" status under the ASA or by accepting the responsibility that came with the vast discretion Defendant enjoyed under the ASA over Plan administration and Plaintiff's assets. *Supra* ¶¶ 39-52. Defendant breached this promise by failing to serve the Plan or to protect Plaintiff's assets with the loyalty and care of a fiduciary. *Supra* ¶¶ 68-100.

119. Defendant also agreed to certain discount guarantees for prescription drug claims. *See Ex. A* at 40-42; *Ex. C* at 40-41. Defendant breached these provisions by failing to secure the promised levels of discounts on individual claims and in the aggregate.

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<sup>25</sup> As noted in Article 20 of the ASA, the ASA shall be construed according to the laws of Virginia, "except to the extent preempted by ERISA or any other applicable provisions of federal law."

120. Defendant agreed to pass on 100% of prescription drug rebates to Plaintiff generated by Plan claims. **Ex. A** at 19; **Ex. C** at 31. Defendant violated this promise by failing to pass on the entirety of those rebates, retaining those rebates, or allowing its affiliated PBMs to retain those rebates.

121. Moreover, Defendant agreed to adjudicate and process claims with at least 95% accuracy and failed to satisfy that contracted standard. *See, e.g.*, **Ex. C** at 12; **Ex. A** at 31. Moreover, Defendant did not pay Plaintiff what it owed for missing its targeted accuracy goals. Preliminary analysis on the limited data produced by Defendant reveals an error rate of at least 10%.

122. As a result of Defendant's breaches, Plaintiff has suffered damages of at least tens of millions of dollars, an estimate which is likely to increase significantly as Plaintiff obtains and analyzes additional information through discovery.

## **II. BREACH OF IMPLIED CONTRACTUAL DUTY OF GOOD FAITH AND FAIR DEALING**

123. Plaintiff incorporates all other allegations in this Complaint as if fully restated here.

124. This claim is brought by Plaintiff Owens & Minor in its individual capacity and, alternatively, on behalf of the Plan.

125. Every agreement carries with it an implied duty of good faith and fair dealing. This implied duty applies even when a written contract provides the defendant discretion to perform a particular act.

126. Defendant enjoyed and exercised discretion under the relevant agreements to determine claims for benefits under the Plan. *Supra* ¶¶ 39, 46. As set forth above in greater detail, Defendant exercised this discretion dishonestly and in bad faith. *See supra* ¶¶ 68-100. There was no rational basis supporting Defendant's misconduct. And the only reason Defendant committed this misconduct was to enrich itself and its affiliates and associates at Plaintiff's expense.

127. Defendant enjoyed and exercised discretion under the relevant agreements to interpret the terms of the Plan. *Supra* ¶¶ 39, 46. As set forth above in greater detail, Defendant exercised this discretion dishonestly and in bad faith. *See supra* ¶¶ 69-70, 73-75, 78-100. There was no rational basis supporting Defendant's misconduct. And the only reason Defendant committed this misconduct was to enrich itself and its affiliates and associates at Plaintiff's expense.

128. Defendant enjoyed and exercised discretion under the relevant agreements to determine amounts of Plaintiff's money Defendant would pay providers and others on claims. *Supra* ¶¶ 39, 40, 41, 45. As set forth above in greater detail, Defendant exercised this discretion dishonestly and in bad faith. *See supra* ¶¶ 68-99. There was no rational basis supporting Defendant's misconduct. And the only reason Defendant committed this misconduct was to enrich itself and its affiliates and associates at Plaintiff's expense.

129. Defendant enjoyed and exercised discretion in determining which providers would provide healthcare to Plan participants and beneficiaries and the amounts of Plaintiff's money Defendant would pay those providers for claims. *Supra* ¶ 39, 42. As set forth above in greater detail, Defendant exercised this discretion dishonestly and in bad



faith. *See supra* ¶¶ 78-82, 87-88. Indeed, Defendant utterly failed to identify and recover overpaid amounts out of self-interest. There was no rational basis supporting Defendant's misconduct. And the only reason Defendant committed this misconduct was to enrich itself and its affiliates and associates at Plaintiff's expense.

130. Defendant enjoyed and exercised discretion in determining whether to audit providers for and recover overpayments by Defendant with Plaintiff's money. *Supra* ¶¶ 39, 50-52. As set forth above in greater detail, Defendant exercised this discretion dishonestly and in bad faith. *See supra* ¶¶ 69-99. There was no rational basis supporting Defendant's misconduct. And the only reason Defendant committed this misconduct was to enrich itself and its affiliates and associates at Plaintiff's expense.

131. Defendant also enjoyed control and discretion under the agreements over sums it or its affiliates retained from the difference of amounts paid by Defendant with Plaintiff's money for prescription drugs and the amount actually invoiced for prescription drugs. *Supra* ¶¶ 39, 42, 43. As set forth above in greater detail, Defendant exercised this discretion dishonestly and in bad faith. *See supra* ¶¶ 73-81, 83-86. There was no rational basis supporting Defendant's misconduct. And the only reason Defendant committed this misconduct was to enrich itself and its affiliates and associates at Plaintiff's expense.

132. Defendant possessed and exercised unfettered discretion under the agreements on what to charge Plaintiff for out-of-network claims. *Supra* ¶¶ 39, 48, 66-67. As set forth above in greater detail, Defendant exercised this discretion dishonestly and in bad faith. *See supra* ¶ 99. There was no rational basis supporting Defendant's misconduct.

And the only reason Defendant committed this misconduct was to enrich itself and its affiliates and associates at Plaintiff's expense.

133. Defendant possessed and exercised unfettered discretion under the agreements to recover overpayments. *Supra* ¶¶ 50-52. As set forth above in greater detail, Defendant exercised this discretion dishonestly and in bad faith. *See supra* ¶¶ 69-99. There was no rational basis supporting Defendant's misconduct. And the only reason Defendant committed this misconduct was to conceal its misconduct and to enrich itself and its affiliates and associates at Plaintiff's expense.

134. Defendant possessed and exercised unfettered discretion over release of information Plaintiff needed to identify fraud, waste, abuse, and overpayments. **Ex. A** at 10-11, art. 11.a, 11.b, 11.d, 12.d. As set forth above in greater detail, Defendant exercised this discretion dishonestly and in bad faith. *See supra* ¶¶ 21-28, 100. There was no rational basis supporting Defendant's misconduct. Indeed, Defendant concealed the data from Plaintiff (and still does) in order to avoid the business, legal, and reputational consequences of its misconduct. And the only reason Defendant committed this misconduct was to enrich itself and its affiliates and associates at Plaintiff's expense.

135. As a result of Defendant's breach of its implied duty of good faith and fair dealing, Plaintiff has suffered damages of at least tens of millions of dollars.

### **III. BREACH OF FIDUCIARY DUTY**

136. Plaintiff incorporates all other allegations in this Complaint as if fully restated here.

137. This claim is brought by Plaintiff Owens & Minor in its individual capacity and, alternatively, on behalf of the Plan.

138. In managing and exercising total control over Plaintiff's money, Defendant owed Plaintiff a fiduciary duty under Virginia law. Plaintiff entrusted Defendant to hold, manage, control, and protect Plaintiff's assets and to commit them fairly and accurately to pay valid bills for healthcare and prescriptions. Plaintiff's money was managed and controlled in trust by Defendant for the purpose of paying healthcare bills of Owens & Minor employees and their beneficiaries. Defendant accepted and acknowledged that Defendant would occupy a position of trust in numerous respects. *Supra* ¶¶ 39-52.

139. As noted above, Defendant had near boundless discretion to determine how much of Plaintiff's money to commit to paying medical bills. *See, e.g., supra* ¶¶ 39, 40, 41, 42, 45. No contract provision defined the precise amounts Defendant would pay for healthcare bills. No contract provision defined Defendant's duty to disclose the specific conflicts of interest at issue here or to refrain from acting according to those conflicts. No contract provision precisely defined Defendant's duty to recover overpayments. To any extent Defendant avers the audit provisions provided for such recovery, Defendant's unfettered, open-ended discretion to determine the method of the audits and to determine which overpayments to recover rendered those provisions illusory, ambiguous, or both. No contract provision precisely defined Defendant's duty to disclose information to Plaintiff sufficient for Plaintiff to determine whether Defendant had committed fraud, waste, and abuse with respect to Plaintiff's assets. These matters were left for Defendant to decide given the position of trust and fiduciary role it filled.

140. Despite holding this position of trust, Defendant breached that trust and its fiduciary duties by overpaying claims to benefit itself and its affiliates and associates, *e.g.*, *supra* ¶¶ 69-75, 78-98; by concealing its misconduct, *e.g.*, *id.* ¶¶ 100; and by failing to recover overpayments and rebates, *e.g.*, *id.* ¶¶ 73-77, 98. As a result, Defendant spent more of Plaintiff's money on healthcare claims than it would have had it upheld its fiduciary duty.

141. As set forth above, Defendant acted in bad faith, managed and spent Plaintiff's money unreasonably, used Plaintiff's money to self-deal, and acted pursuant to conflicts of interest, including Defendant's own desire to use Plaintiff's money to generate revenue for Defendant and its affiliates and associates that was not disclosed in the relevant agreements. Specifically, Defendant violated its fiduciary duties by:

- i. Causing Plaintiff to grossly overpay claims, including payments to certain providers exceeding 100% of charges actually billed by those providers, *supra* ¶¶ 69-70;
- ii. Causing Plaintiff to pay for the same medical claims or identical services multiple times, *supra* ¶¶ 71-72;
- iii. Improperly classifying affordable generic drugs as specialty pharmaceuticals, which resulted in Plaintiff paying excessive prices—or receiving less return in discounts and rebates—for generic drugs prescribed to Plan participants and beneficiaries, and paid by Plaintiff, *supra* ¶¶ 73-75;

- iv. Withholding pharmaceutical rebates from Plaintiff, thereby reducing Plaintiff's assets and effectively causing overpayment of claims, *supra* ¶¶ 76-77;
- v. Using Plaintiff's funds to pay more for prescriptions than charged by providers—a practice called “spread pricing”—which caused Plaintiff to pay significantly more for prescription drugs while allowing Defendant or its affiliates to retain the excess, *supra* ¶¶ 78-79;
- vi. Steering, requiring, or otherwise encouraging Plan participants and beneficiaries to use Defendant-affiliated providers and intermediaries who charged more for the same or lesser quality of care and who passed on the excess of these payments to Defendant or its affiliated companies, *supra* ¶¶ 80-81;
- vii. Knowingly or negligently engaging intermediaries between Defendant and providers who required payment well in excess of providers' charges and pocketing the difference paid by Plaintiff, *supra* ¶ 82;
- viii. Failing to meet discount and rebate guarantees for prescription drug claims and otherwise failing to secure reasonably available discounts and rebates for prescription drug claims, *supra* ¶ 83-85;
- ix. Paying for services not actually provided, which could have been detected with reasonable prudence and effort, *supra* ¶ 86;
- x. Protecting its fully insured segment—where Defendant pays claims from its own assets—by securing less favorable discount arrangements with

network providers for Plaintiff in exchange for more favorable discounts in Defendant's fully insured segment, *supra* ¶¶ 87-88;

- xi. Improperly paying claims for outpatient services for inpatient patients that should not have been billed because those billed outpatient services were paid as part of inpatient services, *supra* ¶¶ 89-90;
- xii. Paying claims that were coded incorrectly, which violated internal or external billing and coding rules and guidelines, or which exceeded Defendant's published negotiated rates with providers despite the fact that Defendant either knew those claims were coded or billed incorrectly or would have known had it exercised reasonable care and placed Plaintiff's and Plan members' interests above its own, *supra* ¶¶ 91-93;
- xiii. Paying for multiple or excessive units of specific treatments in a given day (or other time period) when applicable coding rules and standards prohibited multiple, or more than a certain number of, units in a given day (or time period), *supra* ¶¶ 94-95;
- xiv. Paying hospice charges beyond the acceptable timeframe without recertification, *supra* ¶¶ 96-97;
- xv. Through the BlueCard program, with actual or constructive knowledge, transferring Plan assets to parties in interest, various host Blues and the Association, in the form of overpayments for fees and services, the withholding of Plaintiff's assets in "variance accounts," and the failure to return those assets to Plaintiff, *supra* ¶¶ 56-65, 98;

xvi. Through arrangements with MultiPlan and similar vendors as alleged above, causing Plaintiff to pay exorbitant, unreasonable fees to Defendant and vendors, *supra* ¶ 99;

xvii. Failing to inform Plaintiff of these actions and the costs these actions imposed on Plaintiff when doing so reduced Plaintiff's assets while enriching Defendant and its affiliated companies, *supra* ¶ 100.

142. As a result of these violations, Plaintiff has suffered damages of at least tens of millions of dollars.

#### IV. FRAUDULENT FAILURE TO DISCLOSE

143. Plaintiff incorporates all other allegations in this Complaint as if fully restated here.

144. This claim is brought by Plaintiff Owens & Minor in its individual capacity and, alternatively, on behalf of the Plan.

145. As alleged above, Plaintiff relied on Defendant completely to determine how much Plaintiff would pay on healthcare claims. *See, e.g., supra* ¶¶ 39, 40, 41, 42, 45. Plaintiff relied on Defendant completely to interpret the Plan and to ensure the Plan was managed in a way that prevented fraud, waste, and abuse. *See also supra* ¶¶ 15-17, 32. Defendant freely accepted and agreed to undertake this position of trust. *Supra* ¶¶ 39-52. Defendant therefore owed a duty to disclose to Plaintiff the information it needed to (i) identify fraud, waste, and abuse in Defendant's management of Plaintiff's Plan and money and (ii) clarify and understand Defendant's reports on Plan performance and Defendant's expenditures of Plaintiff's money.

146. Defendant knew that Plaintiff assumed it was receiving reasonably available discounts from providers and rebates from prescription claims. Defendant knew that Plaintiff assumed Defendant's only form of payment for its management of the Plan and Plaintiff's money was disclosed by the ASA. Defendant knew that Plaintiff assumed Defendant was classifying prescription claims—including the generic-versus-specialty classification described above—in a manner that was faithful to the truth and was in Plaintiff's interest. *Supra* ¶¶ 73-74. Defendant concealed its misconduct and its motives for misconduct alleged above. *See supra* ¶¶ 21-28, 100. Defendant concealed these facts in an effort to (i) retain Plaintiff as a customer; (ii) prevent reputational harm that would result if the public and other plan sponsors knew of Defendant's double-dealing, neglect, and double-dipping; (iii) retain the quid pro quo bargains from providers alleged above that benefitted Defendant to Plaintiff's detriment; and (iv) preserve the ability to enrich itself and its affiliated companies through kickbacks and improperly retained rebates.

147. Had Defendant revealed its harmful self-serving misconduct, Plaintiff would have terminated Defendant immediately. But as a result of Defendant's fraudulent concealment and omissions, Plaintiff employed Defendant to manage the Plan and Plaintiff's money and continued to employ Defendant for several years. As a result of Defendant's fraudulent concealment and omissions, Plaintiff was unable to protect itself and its assets from Defendant's misconduct. During the time of Defendant's fraudulent concealment, Defendant overspent Plaintiff's money for claims and was unjustly enriched through quid pro quo dealings and retention of ill-gotten money for itself and its affiliates



and associates as alleged above. *Supra* ¶¶ 68-100. Thus, Defendant harmed Plaintiff through this fraudulent concealment and was unjustly enriched.

148. As a result of Defendant's fraudulent omissions, Plaintiff employed Defendant as the Plan's TPA and retained its "services" from 2017 to 2023. During that same time period, Defendant caused Plaintiff to incur tens of millions of dollars in losses by virtue of its misconduct detailed above. Defendant has also retained monies it received by virtue of its fraud.

## V. NEGLIGENCE

149. Plaintiff incorporates all other allegations in this Complaint as if fully restated here.

150. This claim is brought by Plaintiff Owens & Minor in its individual capacity and, alternatively, on behalf of the Plan.

151. This cause of action assumes in the alternative that Defendant did not intentionally carry out the misconduct alleged above. *See supra* ¶¶ 68-100.

152. Defendant engaged PBMs and its network providers to provide healthcare and prescription products to those whom Defendant allowed to use its network. Relevant here, Defendant also paid its PBMs and network providers with Plaintiff's money. Defendant used Plaintiff's money to pay its PBMs and network providers for services and prescriptions. As Plaintiff's agent for this purpose, Defendant owed a duty to monitor and supervise its PBMs and providers with respect to their coding and billing of claims submitted to ERISA and non-ERISA healthcare plans.

153. With respect to all circumstances where Defendant used Plaintiff's money to pay its contracted PBMs and providers, Defendant owed a duty of care to supervise and monitor its non-fiduciary PBMs and network providers to prevent overbilling, retention of rebates due and owing to Plaintiff, and coding errors. Defendant knew or should have known that its failure to monitor and supervise these agents, affiliates, and associates would increase costs to Plaintiff. As alleged above, these non-fiduciary actors, who acted under and subject to Defendant's control and supervision, submitted bills to Plaintiff for miscoded charges, charges that were grossly excessive, and charges that entitled Plaintiff to discounts and rebates that these non-fiduciary PBMs and network providers improperly failed to honor. *Supra* ¶¶ 68-79, 82-86, 89-97, 100. As a result of Defendant's failure to monitor and correct those bills—and its failure to identify and rectify overpayments and improperly retained rebates—Defendant harmed Plaintiff. *Id.*

154. For purposes of this claim, Plaintiff does not allege that certain services should or should not have been provided under the Plan. But these non-fiduciary actors' actions did cause Plaintiff to pay more than it should have. And Defendant's failure to supervise its nonfiduciary PBMs and network providers by reviewing and ordering the correction of the bills they submitted to Plaintiff caused Plaintiff to pay more than it otherwise would have. A reasonable TPA in Defendant's position—in paying bills submitted by its agents, affiliates, and associates for Defendant's principal to pay and paying those bills with a third party's money—would have exercised reasonable care to ensure the bills were correct. In this context, a reasonable TPA in Defendant's position would have exercised reasonable care to ensure the bills were properly coded and were not

excessive. Defendant failed to do this, however, and caused Plaintiff to pay excessive amounts on bills—measured on an individual basis and in the aggregate—from providers and PBMs.

155. Defendant also had access to Plaintiff's money and unlimited authority to use it to pay Defendant's network providers and PBMs. With this authority as Plaintiff's agent, Defendant owed a duty of reasonable care to ensure it was not overpaying by paying miscoded bills and bills for excessive charges. Defendant also owed a duty to ensure that payments were decreased or offset by discounts and rebates to which Defendant and its non-fiduciary network providers and PBMs agreed would apply to Defendant's payment of claims on Plaintiff's behalf. But Defendant negligently and recklessly increased costs to Plaintiff by overpaying bills that were obviously excessive and miscoded and by failing to collect rebates and recognize discounts. *Supra* ¶¶ 68-79, 83-86, 89-98. A reasonably prudent TPA in Defendant's position would have systems and protocols in place to prevent or recover such payments. Defendant failed to do so.

156. As a result of Defendant's negligent acts, Plaintiff overpaid for medical and prescription claims.

157. As a result of these actions, Plaintiff suffered at least tens of millions of dollars in damages. Moreover, Defendant has received and retained revenue exceeding its fair, disclosed payment for TPA services.

### **TOLLING OF LIMITATIONS PERIODS**

158. As noted above, a contract provides that the statute of limitations for Plaintiff's claims have been tolled. The effect of that tolling agreement is that, for purposes

of claims that existed as of February 13, 2023, Plaintiff's Original Complaint is treated as if it were filed February 13, 2023, for limitations purposes.

159. Further, with the exercise of reasonable diligence, Plaintiff could not have discovered the misconduct alleged and resulting losses supporting Plaintiff's claims for damages and losses until July 2024. Plaintiff's inability to discover the facts and losses supporting Plaintiff's claims for damages was caused by Defendant's fraud, concealment, and obstruction. Specifically, Defendant intentionally reported false information to Plaintiff, which generally indicated that Defendant complied with its relevant duties and managed the Plan and its assets as a loyal and prudent fiduciary. Defendant's reports to Plaintiff were designed to offer assurances to Plaintiff and to prevent Plaintiff from investigating potential misconduct and damages at issue in this case. For instance, Defendant did not report that it used Plan funds to pay duplicate claims. Defendant did not report that it used Plan funds to pay more than billed amounts for certain claims. Defendant did not report that it or its affiliates pocketed prescription rebates that the Plan should have received. Instead, Defendant repeatedly reported and represented to Plaintiff that it served as a loyal, prudent fiduciary for the plan and limited Plan costs accordingly.

160. While owing a duty to disclose its misconduct alleged in this Complaint under the ASA and by virtue of its fiduciary role, Defendant refused to disclose its misconduct or the losses sustained by that misconduct. Moreover, Defendant actively concealed its misconduct and Plan losses by concealing and refusing to share the Plan's claims data to Plaintiff. The misconduct and losses at issue in this lawsuit were undetectable and unknowable to Plaintiff without the Plan's claims data. As noted above,

Plaintiff began requesting the Plan's claims data from Defendant in 2021. Given the timing of Plaintiff's receipt of some of the claims data and the time and expertise necessary to analyze that data, Plaintiff could not have realized the misconduct and damages at issue until July 2024.

161. By way of example, until Plaintiff received the claims data in late December 2023 and had an opportunity to analyze that data, Plaintiff had no way of knowing Defendant charged Plaintiff more on certain claims than was billed by the relevant provider. Plaintiff had no way of knowing that Defendant withheld prescription rebates belonging to Plaintiff. Plaintiff's inability to uncover this and other alleged misconduct and the damages it caused existed until Plaintiff received a portion of the claims data and had a reasonable opportunity to analyze it, which did not occur before July 2024.

### **JURY DEMAND**

162. Plaintiff Owens & Minor, individually and on behalf of the Plan, hereby demands a trial by jury for all issues triable by jury.

### **PRAYER FOR RELIEF**

163. Plaintiff seeks an order requiring Defendant to pay damages caused by the misconduct described above in an amount to be proved at trial.

164. Plaintiff seeks an order requiring Defendant to return monies Defendant received or paid by the Plan by virtue of misconduct alleged above and all other applicable equitable relief provided by ERISA.

165. Plaintiff seeks reasonable attorney's fees and costs.

*[Signature Block on Next Page]*

Dated: February 7, 2025

Respectfully submitted,

OWENS & MINOR, INC. and  
OWENS & MINOR FLEXIBLE  
BENEFITS PLAN

By:

/s/

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**ATTORNEYS FOR PLAINTIFFS**

# EXHIBIT A



## ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement ("Agreement") is entered into by and between Owens & Minor Medical, Inc. ("Employer") and HealthKeepers, Inc. and Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield ("Anthem") and is effective as of June 1, 2017 upon the following terms and conditions:

1. Employer is the sponsor of a self-funded Group Health Plan (as defined below) providing, among other things, health care benefits to certain eligible employees and their qualified dependents.
2. Employer desires to retain Anthem as an independent contractor to administer certain elements of Employer's Group Health Plan.
3. Anthem desires to administer certain elements of Employer's Group Health Plan pursuant to the terms and conditions of this Agreement.

In consideration of the promises and the mutual covenants contained in this Agreement, Anthem and Employer (the "Party" or "Parties" as appropriate) agree as follows:

### ARTICLE 1 - DEFINITIONS

For purposes of this Agreement and any amendments, attachments or schedules to this Agreement, the following words and terms have the following meanings unless the context or use clearly indicates another meaning or intent:

**ADMINISTRATIVE SERVICES FEES.** The amount payable to Anthem in consideration of its administrative services and operating expenses as indicated in Section 3 of Schedule A, excluding any cost for stop loss insurance coverage or any other policy of insurance, if applicable. All additional charges not included in the Administrative Services Fees are specified elsewhere in this Agreement.

**AGREEMENT PERIOD.** The period of time indicated in Section 1 of Schedule A.

**ANTHEM AFFILIATE.** An entity controlling, under common control with or controlled by Anthem.

**BENEFITS BOOKLET.** A description of the portion of the health care benefits provided under the Plan that is administered by Anthem.

**BILLED CHARGES.** The amount that appears on a Member's Claim form (or other written notification acceptable to Anthem that Covered Services have been provided) as the Provider's charge for the services rendered to a Member, without any adjustment or reduction and irrespective of any applicable reimbursement arrangement with the Provider.

**BLUE CROSS BLUE SHIELD ASSOCIATION ("BCBSA").** An association of independent Blue Cross and Blue Shield companies.

**CLAIM.** Written or electronic notice of a request for reimbursement of any health care service or supply on a form acceptable to Anthem.

**CLAIMS RUNOUT SERVICES.** Processing and payment of Claims that are incurred but unreported and/or unpaid as of the date this Agreement terminates.

**COVERED SERVICE.** Any health care service or supply rendered to Members for which benefits are eligible for reimbursement pursuant to the terms of the applicable Benefits Booklet.

**EMPLOYER AFFILIATES.** Companies affiliated with Employer that are participating in the Plan and which, along with the Employer constitute a single "control group" as that term is used in the Internal Revenue Code.

**ERISA.** The Employee Retirement Income Security Act of 1974, as amended, and regulations promulgated thereunder.

**GROUP HEALTH PLAN OR PLAN.** An employee welfare benefit plan (as defined in Section 3(1) of ERISA) established by the Employer, in effect as of the Effective Date, as described in the Plan Documents, as they may be amended from time to time.

**INTER-PLAN ARRANGEMENTS.** Blue Cross and Blue Shield Association programs, including the BlueCard Program, where Anthem can process certain Claims for Covered Services received by Members, which may include accessing the reimbursement arrangement of a Provider that has contracted with another Blue Cross and/or Blue Shield plan.

**INVOICE DUE DATE.** The date on the invoice provided to Employer indicating when payment is due.

**MEMBER.** The individuals, including the Subscriber and his/her dependents, as defined in the Benefits Booklet, who have satisfied the Plan eligibility requirements of Employer, applied for coverage, and been enrolled for Plan benefits.

**NETWORK PROVIDER.** A physician, health professional, hospital, pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with Anthem to provide Covered Services to Members through negotiated reimbursement arrangements.

**PAID CLAIM.** The amount charged to Employer for Covered Services or services provided during the term of this Agreement and any Claims Runout Period. Paid Claims may also include any applicable surcharges assessed by a state or government agency and any applicable interest paid. In addition, Paid Claims shall be determined as follows:

1. Provider and Vendor Claims. Except as otherwise provided in this Agreement, Paid Claims shall mean the amount Anthem actually pays the Provider or Vendor without regard to: (i) whether Anthem reimburses such Provider or Vendor on a percentage of charges basis, a fixed payment basis, a global fee basis, single case rate, or other reimbursement methodology; (ii) whether such amount is more or less than the Provider's or Vendor's actual Billed Charges for a particular service or supply; or (iii) whether such payments are increased or decreased by the Provider's or Vendor's achievement of, or failure to achieve, certain specified goals, outcomes or standards adopted by Anthem.
2. Prescription Drug Claims. If applicable to the Plan benefits as indicated in Schedule B, Paid Claims for Prescription Drugs shall mean an amount that Anthem invoices Employer for Prescription Drugs dispensed to Members by pharmacies. Anthem shall retain the difference, if any, between the amount invoiced to Employer and the amount paid to the pharmacy benefit manager ("PBM") for Prescription Drugs dispensed to Members as a portion of Anthem's reasonable compensation for services under this Agreement.
3. Payment Innovation Programs. If a Provider or Vendor participates in any Anthem payment innovation program, excluding any programs described in paragraph 1 of this provision, in which performance incentives, rewards or bonuses are paid based on the achievement of cost, quality, efficiency, or service standards or metrics adopted by Anthem ("Payment Innovation Programs"), Paid Claims shall also include the amount of such payments to Providers or Vendors for these Payment Innovation Programs. Such payments may be charged to Employer on a per Claim, lump sum, per Subscriber, or per Member basis and shall be based on Anthem's predetermined methodology for such Payment Innovation Program, as may be amended from time to time. The total monies charged in advance to fund a Payment Innovation Program shall be actuarially determined as the amount necessary to fund the expected payments attributable to the Payment Innovation Program. Prior to its implementation, Anthem shall provide Employer with a description of the Payment Innovation Program, the methodology that will be utilized to charge the Employer, and any reconciliation process performed in connection with such program. Payments to Providers or Vendors under these Payment Innovation Programs shall not impact Member cost shares.
4. Fees Paid to Manage and/or Coordinate Care or Costs. Paid Claims may also include fees paid to Providers or Vendors for managing and/or coordinating the care or cost of care for designated Members.
5. Claims Payment Pursuant to any Judgment, Settlement, Legal or Administrative Proceeding. Paid Claims shall include any Claim amount paid as the result of a settlement, judgment, or legal, regulatory or administrative proceeding brought against the Plan and/or Anthem, or otherwise agreed to by Anthem, with respect to the decisions made by Anthem regarding the coverage of or amounts paid for services under the terms of the Plan. Paid Claims also includes any amount paid as a result of Anthem's billing dispute resolution procedures with a Provider or Vendor. Any Claims paid pursuant to this provision will count towards any stop loss accumulators under a stop loss agreement with Anthem.
6. Claims Payment Pursuant to Inter-Plan Arrangements and Other BCBSA Programs. Paid Claims shall include any amount paid for Covered Services that are processed through Inter-Plan Arrangements or for any amounts paid for Covered Services provided through another BCBSA program (e.g., BCBSA Blue Distinction Centers for Transplant). More information about Inter-Plan Arrangements is found in the Inter-Plan Arrangements Schedule of this Agreement.

7. Claims Payment Pursuant to a Consumer Directed Health Plan Account. If applicable to Plan benefits and as indicated on Schedule B of this Agreement, Paid Claims shall include any amount actually paid by Anthem from a consumer directed health plan account, such as a health reimbursement account or a health incentive account.

**PLAN DOCUMENTS.** The documents that set forth the terms of the Plan, and which include the Summary Plan Description and the Benefits Booklet.

**PRESCRIPTION DRUG.** Insulin and those drugs and drug compounds that are included in the U.S. Pharmacopoeia and that are required to be dispensed pursuant to a prescription or that are otherwise included on Anthem's formulary (e.g., certain over-the-counter drugs).

**PROPRIETARY INFORMATION AND CONFIDENTIAL INFORMATION.** Employer's Proprietary Information is information about the systems, procedures, methodologies and practices used by Employer to run its operations and the Plan and other non-public information about Employer. Anthem's Proprietary Information is non-public, trade secret, commercially valuable, or competitively sensitive information, or other material and information relating to the products, business, or activities of Anthem or an Anthem Affiliate, including but not limited to: (1) Information about Anthem's Provider networks, Provider negotiated fees, Provider discounts, and Provider contract terms; (2) information about the systems, procedures, methodologies, and practices used by Anthem and Anthem Affiliates in performing their services such as underwriting, Claims processing, Claims payment, and health care management activities; and (3) combinations of data elements that could enable information of this kind to be derived or calculated. Anthem's Confidential Information is information that Anthem or an Anthem Affiliate is obligated by law or contract to protect, including: (1) Social Security numbers; (2) Provider tax identification numbers (TINs); (3) National Provider Identification Numbers (NPIs); (4) Provider names, Provider addresses, and other identifying information about Providers; and (5) drug enforcement administration (DEA) numbers, pharmacy numbers, and other identifying information about pharmacies.

**PROVIDER.** A duly licensed physician, health professional, hospital, pharmacy or other individual, organization and/or facility that provides health services or supplies within the scope of an applicable license and/or certification and meets any other requirements set forth in the Benefits Booklet.

**SUBSCRIBER.** An employee or retiree of Employer or other eligible person (other than a dependent) who is enrolled in the Plan.

**SUMMARY PLAN DESCRIPTION ("SPD").** A document provided to Subscribers by Employer or its designee that describes the health care benefits available to Members under the Plan, their rights under the Plan and the obligations of the Plan. This document may incorporate the Benefits Booklet. In the event of any conflict or inconsistency between the Summary Plan Description and the Benefits Booklet, the terms of the Benefits Booklet shall control Anthem's performance under this Agreement.

**VENDOR.** A person or entity other than a Provider, including an Anthem Affiliate, that provides services or supplies pursuant to a contract with Anthem.

## ARTICLE 2 - ADMINISTRATIVE SERVICES PROVIDED BY ANTHEM

- a. Anthem shall process the enrollment of eligible individuals and termination of Members as directed by the Employer subject to the provisions of this Agreement. Anthem shall, with the assistance of Employer, respond to direct routine inquiries made to it by employees and other persons concerning eligibility in the Plan.
- b. Anthem shall perform the following Claims administrative services:
  1. Process Claims with a Claims Incurred Date indicated in Section 1 of Schedule A and provide customer service, including investigating and reviewing such Claims to determine what amount, if any, is due and payable according to the terms and conditions of the Benefits Booklet and this Agreement. Anthem shall perform coordination of benefits ("COB") with other payors, including Medicare. In processing Claims, Anthem shall utilize Anthem's medical policies and medical policy exception process, its definition of medical necessity, its precertification and/or preauthorization policies, Provider contract requirements and applicable Claim timely filing limits.
  2. Disburse to the applicable individuals or entities (including Providers and Vendors) payments that it determines to be due according to the provisions of the Benefits Booklet.

3. Provide notice in writing when a Claim for benefits has been denied which notice shall set forth the reasons for the denial and the right to a full and fair review of the denial under the terms of the Benefits Booklet and shall otherwise satisfy applicable regulatory requirements, including those of ERISA, governing the notice of a denied Claim.
- c. Pursuant to Section 405(c)(1) of ERISA, Employer delegates to Anthem fiduciary authority to determine claims for benefits under the Plan as well as the authority to act as the appropriate fiduciary under Section 503 of ERISA to determine appeals of any adverse benefit determinations under the Plan. Anthem shall administer complaints, appeals and requests for independent review according to Anthem's complaint and appeals policy, and any applicable law or regulation, unless otherwise provided in the Benefits Booklet. In carrying out this authority, Anthem is delegated full discretion to determine eligibility for benefits under the Plan and to interpret the terms of the Plan. Anthem shall be deemed to have properly exercised such authority unless a Member proves that Anthem has abused its discretion or that its decision is arbitrary and capricious. Anthem is a fiduciary of the Plan only to the extent necessary to perform its obligations and duties as expressed in this Agreement and only to the extent that its performance of such actions constitutes fiduciary action under ERISA. Anthem shall have no fiduciary responsibility in connection with any other element of the administration of the Plan. Anthem shall not act as the "plan administrator" nor shall it be a "named fiduciary" of the Plan. Anthem shall charge Employer the fee described in Section 3.C of Schedule A for any independent review conducted pursuant to this provision.
  - d. Anthem shall have the authority, in its reasonable discretion, to institute from time to time, utilization management, case management, disease management or wellness pilot initiatives in certain designated geographic areas. These pilot initiatives are part of Anthem's ongoing effort to find innovative ways to make available high quality and more affordable healthcare services. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of benefits which are not provided in the applicable Benefits Booklet, unless otherwise agreed to by the Employer. Anthem reserves the right to discontinue a pilot initiative at any time without advance notice to Employer.
  - e. Anthem shall perform recovery services as provided in Article 13.
  - f. Anthem shall issue identification cards to Subscribers and/or Members, as applicable, and the content and design of the identification cards shall comply with BCBSA regulations.
  - g. This provision is intentionally omitted in its entirety.
  - h. Anthem shall provide Members and potential Members access to an online directory of Providers contracted with Anthem ("Provider Directories"). Such Provider Directories shall also be available and distributed in booklet format upon Member request. Additionally, if applicable to Plan benefits, Anthem shall ensure that Members and potential Members have access to the BlueCard directory of Providers via a website sponsored by BCBSA.
  - i. Anthem reserves the right to make benefit payments to either Providers or Members at its reasonable discretion. Employer agrees that the terms of the Plan will include provisions for supporting such discretion in determining the direction of payment including, but not limited to, a provision prohibiting Members from assigning their rights to receive benefit payments, unless otherwise prohibited by applicable law.
  - j. If applicable to the Plan benefits and as indicated in Schedule B of this Agreement, Anthem may provide or arrange for the provision of the following managed care services:
    1. Conduct medical necessity review, utilization review, and a referral process, which may include, but is not limited to: (a) preadmission review to evaluate and determine the medical necessity of an admission or procedure and the appropriate level of care, and for an inpatient admission, to authorize an initial length of stay; (b) concurrent review throughout the course of the inpatient admission for authorization of additional days of care as warranted by the patient's medical condition; (c) retrospective review; and (d) authorizing a referral to a non-Network Provider. Anthem shall have the authority to waive a requirement if, in Anthem's discretion, such exception is in the best interest of the Member or the Plan, or is in furtherance of the provision of cost effective services under this Agreement.
    2. Perform case management to identify short and long term treatment programs in cases of severe or chronic illness or injury. Anthem may, but is not required to, customize benefits in limited circumstances by approving otherwise non-Covered Services if, in the discretion of Anthem, such exception is in the best interest of the Member and the Plan.

3. Provide access to a specialty network of Providers if the Plan includes a specialty network. Anthem reserves the right to establish specialty networks for certain specialty or referral care.
  4. Provide any other managed care services incident to or necessary for the performance of the services set forth in this Article 2.
- k. If applicable to the Plan benefits and as indicated in Schedule A or B of this Agreement, Anthem shall offer wellness programs and other programs to help Employer effectively manage the cost of care, and Employer shall pay fees for the programs selected by Employer only if such fees are indicated in Section 3(B) of Schedule A. Employer shall abide by all applicable policies and procedures of the programs selected, which may require Employer to provide requested information prior to Anthem initiating the service.
  - l. On behalf of Employer, Anthem shall produce and maintain a master copy of the Benefits Booklet and make changes and amendments to the master copy of the Benefits Booklet and incorporate any approved changes or amendments pursuant to Article 18(a) of this Agreement. Employer shall determine, in its sole and reasonable discretion, whether Anthem has accurately produced the Benefits Booklet and has fully implemented the approved changes or amendments. Until Employer has approved the Benefits Booklet, Anthem will administer the quoted benefits according to Anthem's most similar standard Benefits Booklet language.
  - m. Anthem will provide Employer with Plan data and assistance necessary for preparation of the Plan's information returns and forms required by ERISA or other federal or state laws. Anthem shall prepare and mail all IRS Form 1099's and any other similar form that is given to Providers or brokers. Form 5500s are the sole responsibility of Employer; however, Anthem shall provide timely information and, if requested, assistance. Anthem will disclose its fee and compensation information to Employer, as required by applicable law, for Employer to complete its Form 5500 and assess its compliance with section 408(b)(2) of ERISA and any applicable regulations promulgated there under. Employer is solely responsible for preparing the summary annual reports.
  - n. Anthem shall administer unclaimed funds pursuant to unclaimed property or escheat laws and shall make any required payment and file any required reports under such laws.
  - o. Unless otherwise agreed to by the Parties and specified in the Benefits Booklet, Anthem's standard policies and procedures, as well as Provider contracts, as they may be amended from time to time, will be used in the provision of services specified in this Agreement. In the event of any conflict between this Agreement and any of Anthem's policies and procedures, this Agreement will govern.
  - p. This provision is intentionally omitted.
  - q. Select state laws require Employers to finance health related initiatives through residency-based assessments and/or surcharges added to certain Paid Claims. After Employer completes any applicable forms, Anthem shall make all assessment and/or surcharge payments on behalf of Employer to the appropriate pools administered by the respective states, based primarily upon Anthem's Paid Claims information and Member information provided to Anthem by Employer. Examples of such assessments and surcharges include, but are not limited to, the Massachusetts Health Safety Net Trust Fund, the New York Health Care Reform Act and the Michigan Health Insurance Claims Assessment Act.
  - r. Anthem shall provide required notices describing Member's rights under the Women's Health and Cancer Rights Act (WHCRA) upon a Member's enrollment and at least annually thereafter.
  - s. Anthem shall have the authority, in its sole discretion, to build and maintain its Provider network on its own behalf. In building and maintaining its Provider network, Anthem is not acting on behalf of or as an agent for any Employer or member. Nothing in this Agreement shall be interpreted to require Anthem to maintain negotiated fees or reimbursement arrangements or other relationships with certain Providers or Vendors or to negotiate on behalf of or for the benefit of Employer or Employer's Members. Anthem will be solely responsible for acting as a liaison with Providers including, but not limited to, responding to Provider inquiries, negotiating contract language and negotiating rates with Providers or auditing Providers, and Employer agrees that it will be subject to the terms and conditions of these agreements.
  - t. If a catastrophic event (whether weather-related, caused by a natural disaster, or caused by war, terrorism, or similar event) occurs that affects Members in one or more locations, and such catastrophic event prevents or interferes with Anthem's ability to conduct its normal business with respect to such Members or prevents or interferes with Members' ability to access their benefits, Anthem shall have the right, without



first seeking consent from Employer, to take reasonable and necessary steps to process Claims and provide managed care services in a manner that may be inconsistent with the Benefits Booklet in order to minimize the effect such catastrophic event has on Members. As soon as practicable after a catastrophic event, Anthem shall report its actions to Employer. Employer shall reimburse Anthem for amounts paid in good faith under the circumstances and such amounts shall constitute Paid Claims, even if the charges incurred were not for services otherwise covered under the Benefits Booklet.

- u. Anthem shall submit any claim that is required to be filed under any stop loss policy issued by Anthem or an Anthem Affiliate. Anthem shall have no obligation to prepare or file any claim for excess risk or stop loss coverage under a policy not issued by Anthem or an Anthem Affiliate. Anthem shall provide Employer with Claims data pursuant to Article 11 of this Agreement if Employer chooses to file a claim under a stop loss policy issued by an entity other than Anthem or an Anthem Affiliate. Anthem shall assume no liability or responsibility to Employer for inconsistencies between the determination of Covered Services under the Benefits Booklet and this Agreement and the determination of coverage by an unaffiliated stop loss carrier.
- v. Anthem shall assist Employer in determining whether its Prescription Drug benefit constitutes "creditable prescription drug coverage" as that term is used under the Medicare Part D laws (specifically, 42 C.F.R. 423.56). Unless otherwise agreed to by the Parties, Employer shall be solely responsible for communicating with Members regarding creditable prescription drug coverage matters.
- w. If a Member is a Massachusetts resident, Anthem shall mail the Member any notices required by the Massachusetts Health Care Reform Act ("HCRA") reflecting coverage during the current and prior Agreement Period. If a Member works in Massachusetts for Employer, but resides in another State, Anthem will only provide such notices if Employer notifies Anthem at least 60 days prior to any notice deadline imposed by HCRA that such Member requires the HCRA notices.
- x. Anthem is the responsible reporting entity ("RRE") for the Plan as that term is defined pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007. In order to fulfill its RRE obligation, Anthem requires information from the Employer, including, but not limited to, Member Social Security Numbers. Employer shall cooperate with Anthem and timely respond to any request for information made by Anthem.
- y. Anthem will provide Employer with Plan information and assistance necessary for the preparation of the Plan's Summary of Benefits and Coverage ("SBC") related to the elements of the Plan that Anthem administers. Employer is solely responsible for ensuring that the SBC accurately reflects the benefits Employer will offer and for finalizing and distributing the SBC to Subscribers. Notwithstanding the provisions in Article 18(a), if Employer's open enrollment period is at a time other than 30 days prior to the end of an Agreement Period, Employer agrees to provide Anthem with any changes to the benefits Anthem administers at least 60 days prior to the start of the open enrollment period.

### ARTICLE 3 - OBLIGATIONS OF EMPLOYER

- a. Employer shall furnish to Anthem initial eligibility information regarding Members. Employer is responsible for determining eligibility of individuals and advising Anthem in a timely manner, through a method agreed upon by the Parties, as to which employees, dependents, and other individuals are to be enrolled Members. Anthem reserves the right to limit the effective date of retroactive enrollment to a date not earlier than 60 days prior to the date notice is received. Such retroactive enrollments shall be subject to Anthem's receipt of any applicable fees as indicated in Section 3 of Schedule A. Employer shall keep such applicable records and furnish to Anthem such notification and other information as may be required by Anthem for the purpose of enrolling Members, processing terminations, effecting COBRA coverage elections, effecting changes in single or family coverage status, effecting changes due to a Member becoming eligible or ineligible for Medicare, effecting changes due to a leave of absence, or for any other purpose reasonably related to the administration of eligibility under this Agreement. Employer acknowledges that prompt and complete furnishing of the required eligibility information is essential to the timely, accurate, and efficient processing of Claims.

Employer shall notify Anthem monthly of the Subscribers, dependents, or other individuals that will be or have become ineligible for benefits under the Plan. Upon receipt of such notice, Anthem shall terminate coverage effective as of the date specified in the Benefits Booklet. Employer shall give Anthem advance notice, if possible, of any Member's expected termination and/or retirement. Anthem reserves the right to limit retroactive terminations to a maximum of 60 days prior to the date notice is received. Anthem shall credit Employer any applicable fees for such retroactive terminations as indicated in Section 3 of Schedule

A.

If Anthem has paid Claims for persons no longer eligible for reasons including, but not limited to, Anthem having been provided inaccurate eligibility information, or Anthem having received notice of a retroactive change to enrollment, then Employer shall reimburse Anthem for all unrecovered Paid Claim amounts to the extent that the amounts have not already been paid by Employer.

- b. Employer acknowledges that it or its designee(s) serves as the "plan sponsor, "plan administrator" and "named fiduciary" as those terms are defined in ERISA. Employer has all discretionary authority and control over the management of the Plan, and all discretionary authority and responsibility for the administration of the Plan except as delegated to Anthem in Article 2(c) of this Agreement. Anthem does not serve as "plan sponsor", "plan administrator" or as the Plan's "named fiduciary". Employer retains all final authority and responsibility for the Plan and its operation and Anthem is empowered to act on behalf of Employer in connection with the Plan only as expressly stated in this Agreement or as otherwise agreed to by the Parties in writing.
- c. It is understood and agreed that the provision of any notice, election form, or communication and the collection of any applicable premium or fees required by or associated with Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), or any other applicable law governing continuation of health care coverage, shall be the responsibility of Employer and not Anthem, except as otherwise agreed to in a written agreement between the Parties.
- d. Employer is responsible for compliance with the Family and Medical Leave Act ("FMLA") and, to the extent applicable to Employers' wellness program(s), for compliance with the Americans with Disabilities Act, the Internal Revenue Code, federal and state nondiscrimination laws, and other applicable federal and state laws and regulations governing wellness programs.
- e. Employer agrees to and shall collect those contributions from Subscribers that are required by Employer for participation in the Plan. If Employer elects Anthem's stop loss coverage, Employer shall abide by Anthem's participation and contribution guidelines.
- f. Unless otherwise agreed to by the Parties in writing, Employer shall prepare and distribute SPDs, summary annual reports, and all notices or summaries of changes or material modifications to the Plan. Employer shall confirm that when it or its designee prepares the SPD, such SPD will accurately reflect the terms of the Benefits Booklet.
- g. To the extent that Medicare, Medicaid, the Veterans Administration or any other federal or state agency or entity asserts a reimbursement right against Employer, the Plan, or Anthem pursuant to that agency's or entity's rights under applicable law with respect to Claims processed by Anthem under this Agreement, the Employer shall be responsible for reimbursing Anthem any such amounts determined to be owed.
- h. Employer shall give notice to Anthem of the expected occurrence of any of the following events (including a description of the event), with such notice to be given at least 30 days prior to the effective date of the event, unless such advance notice is prohibited by law or contract in which case, notice will be provided as soon as practicable:
  1. Change of Employer's name;
  2. Any merger between or consolidation with another entity where, after such merger or consolidation, Employer is not the controlling entity;
  3. The sale or other transfer of all or substantially all of the assets of either Employer or any Employer Affiliates or the sale or other transfer of the equity of Employer or any Employer Affiliates, or;
  4. Any bankruptcy, receivership, insolvency or inability of Employer to pay its debts as they become due.
- i. The Employer shall have the responsibility, in accordance with state or federal law, to develop procedures for determining whether a medical child support order is a "qualified" medical child support order. The Employer shall provide notice to Anthem once it has made such determination.

- j. The Employer may request Anthem, on an exception basis, to process and pay Claims that were denied by Anthem or take other actions with respect to the Plan that are not specifically set forth in this Agreement or the Benefits Booklet. In such cases, any payments shall not count toward the stop loss accumulators under a stop loss agreement issued by Anthem, unless otherwise agreed to by Anthem. Anthem may charge Employer a processing fee that has been mutually agreed to by the Parties prior to the processing of the Claim. Anthem shall not be responsible for any liability associated with any act or omission undertaken at the direction of, or in accordance with, instructions received from the Employer under this provision.

#### **ARTICLE 4 - CLAIMS PAYMENT METHOD**

- a. Employer shall pay or fund Paid Claims according to the Claims payment method described in Section 4 of Schedule A. Employer shall pay or fund such amounts by the Invoice Due Date. In addition, from time to time, the Parties acknowledge that Employer may request a review of the appropriateness of a Claim payment and, during the review period, Employer shall pay or fund such Claim.
- b. The Parties acknowledge that, from time to time, a Claims adjustment may be necessary as a result of coordination of benefits, subrogation, workers' compensation, other third party recoveries, payment errors and the like, and that the adjustment will take the form of a debit (for an additional amount paid by Anthem) or a credit (for an amount refunded to Employer). The Parties agree that such Claims adjustment shall be treated as an adjustment to the Claims payment made in the billing period in which the adjustment occurs, rather than as a retroactive adjustment to the Claim in the billing period in which it was initially reported as paid. Any Claims credit may be reduced by a fee as indicated in Schedule A of this Agreement. In addition, a credit shall not be provided to Employer for a recovery related to a Claim that was covered under stop loss coverage provided by Anthem.

#### **ARTICLE 5 - ADMINISTRATIVE SERVICES FEES**

During the term of this Agreement, Employer shall pay Anthem the Administrative Services Fees, described in Section 3 of Schedule A. Employer shall pay the Administrative Services Fees and other fees authorized under this Agreement by the applicable Invoice Due Date according to the payment method described in Section 5 of Schedule A.

#### **ARTICLE 6 - RENEWAL SCHEDULES**

If Anthem offers to renew this Agreement at the end of an Agreement Period, then Anthem shall provide Employer with the terms and conditions of the proposed renewal in writing within the time period provided in Section 1 of Schedule A. Employer shall notify Anthem in writing of its selection from the renewal options by indicating its selection and signing Anthem's designated renewal form. If Anthem does not receive a signed acceptance of the renewal from Employer prior to the start of the next Agreement Period, Employer's payment of the amounts set forth in the renewal shall constitute Employer's acceptance of the terms. Anthem shall provide a revised Schedule A that will become part of this Agreement without the necessity of securing Employer's signature.

#### **ARTICLE 7 - CLAIMS RUNOUT SERVICES**

- a. Claims Runout Services shall be provided for the period of time provided in Section 6 of Schedule A (the "Claims Runout Period"), except such Claims Runout services shall not be provided in the event that termination is due to non-payment pursuant to Article 19(a) of this Agreement. During the Claims Runout Period, the terms of this Agreement shall continue to apply. Anthem shall have no obligation to process or pay any Claims or forward Claims to Employer beyond the Claims Runout Period. Any amounts recovered beyond the Claims Runout Period shall be retained by Anthem as reasonable compensation for services under this Agreement. Anthem shall, however, as soon as practicable return any recoveries for which Anthem had received monies, but had not processed the recovery prior to the end of the Claims Runout Period. In addition, Employer shall have no obligation to reimburse Anthem for any amounts paid by Anthem due to adjustments to Claims after the end of the Claims Runout Period.
- b. The Administrative Services Fee for the Claims Runout Period, if applicable, is provided in Section 6 of Schedule A. Paid Claims and the Administrative Services Fee shall be invoiced and paid in the same manner as provided in Sections 4 and 5 of Schedule A, unless otherwise provided or agreed to in writing by



the Parties.

#### ARTICLE 8 - LATE PAYMENT PENALTY

If Employer fails to timely pay or fund any amount due to Anthem under this Agreement, Employer agrees to pay a late payment penalty for each day the payment is late. The late payment penalty shall be calculated at the rate of 12% simple interest per annum (365 days), and shall be included on a subsequent invoice and payable by the Invoice Due Date. If applicable, Employer agrees to reimburse Anthem for any expenses charged to Anthem by a financial institution, Provider or Vendor due to Employer's failure to maintain sufficient funds in a designated bank account. Any acceptance by Anthem of late payments shall not be deemed a waiver of its rights to terminate this Agreement for any future failure of Employer to make timely payments. Anthem will notify Employer in writing of the delinquency before applying any late payment penalty as described in this provision.

#### ARTICLE 9 - HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

- a. Anthem's duties and responsibilities in connection with the requirements imposed by the Health Insurance Portability and Accountability Act ("HIPAA") and the privacy and security regulations promulgated thereunder will be set forth in a separate business associate agreement between the Parties.
- b. In the event the Plan submits Claims or eligibility inquiries or any other HIPAA covered transaction as defined in 45 CFR Part 160 and 162 to Anthem through electronic means, the Plan and Anthem shall comply with all applicable requirements of HIPAA and the Plan and Anthem shall require any of their respective agents or subcontractors to comply with all applicable requirements of HIPAA.

#### ARTICLE 10 - PROPRIETARY AND CONFIDENTIAL INFORMATION

- a. Each Party retains ownership of its Proprietary Information and Confidential Information (collectively "Information") and neither conveys ownership rights in its Information nor acquires ownership rights in the other Party's Information by entering into this Agreement or performing its obligations hereunder. **Nothing in this Agreement shall impair or limit a Party's right to use and disclose its Information for its own lawful business purposes.**
- b. **Each Party shall maintain the other Party's Information in strict confidence, and shall institute commercially reasonable safeguards to protect it.**
- c. **Employer shall use and disclose Anthem's Information solely for the purpose of administering the Plan.** Employer shall not, without Anthem's advance written consent, (1) use or disclose Anthem's Information, or reports or summaries thereof, for any purpose other than administering the Plan; (2) combine Anthem's Information with other data to create or add to an aggregated database that will or could be made available to any third party; (3) combine Anthem's Information provided for a particular purpose with Anthem's Information provided for another purpose; or (4) sell or disclose Anthem's Information to any other person or entity except as expressly permitted by this Article 10.
- d. **Employer may disclose the minimum amount of Anthem's Information necessary to Employer's stop loss carriers, consultants, auditors, and other third parties engaged by Employer (each a "Plan Contractor"), provided that: (i) each such third party needs to know such Information in order to provide services to Employer; (ii) the restrictions set forth in subsection c. of this Article 10 shall apply to each such third party as well as to Employer; and (iii) prior to such disclosure, each such third party shall enter into a confidentiality agreement (or an appropriate amendment to an existing one, as applicable) with Anthem, with respect to the planned disclosure.**
- e. **Upon termination of this Agreement, each Party shall return or destroy the other Party's Information or retain the Information in accordance with its record retention policies and procedures; provided; however that each Party shall continue to comply with the provisions of this Article 10 for as long as it retains the other Party's Information.**
- f. **This Agreement shall not be construed to restrict the use or disclosure of information that: (1) is public knowledge other than as a result of a breach of this Agreement; (2) is independently developed by a Party not in violation of this Agreement; (3) is made available to a Party by any person other than the other Party, provided the source of such information is not subject to any confidentiality obligations with respect to it; or,**

(4) is required to be disclosed pursuant to law, order, regulation or judicial or administrative process, but only to the extent of such required disclosures and after reasonable notice to the other Party.

## ARTICLE 11 - DATA REPORTS

- a. Upon Employer's request and only as permitted by the business associate agreement entered into between the Parties, Anthem will provide Anthem's standard account reporting package. Prior to Anthem providing data or reports to Employer, the Parties must mutually agree to the types, format, content and purpose of the reports requested. If Employer requests from Anthem information that is not part of Anthem's standard account reporting package, and such request is approved by Anthem, Employer agrees to pay a mutually agreed upon charge to Anthem for such additional reports.
- b. If Employer requests Anthem to provide a data extract or report to any Plan Contractor for use on Employer's behalf and Anthem agrees to do so: (i) to the extent such extract or report includes protected health information ("PHI") as defined in HIPAA, Anthem's disclosure of the PHI and Plan Contractor's subsequent obligations with respect to the protection, use, and disclosure of the PHI will be governed by Employer's applicable business associate agreements with Anthem and the Plan Contractor; and (ii) to the extent such data or report includes Anthem's Proprietary Information and/or Anthem's Confidential Information, Employer acknowledges and agrees that Plan Contractor shall be subject to the restrictions set forth in Article 10 of this Agreement and shall enter into a confidentiality agreement with Anthem (or amend an existing one, as applicable) prior to Anthem's release of the extract or report.
- c. Employer agrees not to contact, or to engage or permit a Plan Contractor to contact on Employer's behalf, any health care Provider concerning the information in any reports or data extracts provided by Anthem unless the contact is coordinated by Anthem.
- d. In addition to their unlimited rights to use Anthem's Proprietary Information and Confidential Information, Anthem and Anthem Affiliates shall also have the right to use and disclose other Claim-related data collected in the performance of services under this Agreement or any other agreement between the Parties, so long as: (1) the data is de-identified in a manner consistent with the requirements of HIPAA; or (2) the data is used or disclosed for research, health oversight activities, or other purposes permitted by law; or (3) a Member has consented to the release of his or her individually identifiable data. The data used or disclosed shall be used for a variety of lawful purposes including, but not limited to, research, monitoring, benchmarking and analysis of industry and health care trends. Anthem may receive remuneration for the data only if permitted by HIPAA.

## ARTICLE 12 - CLAIMS AUDIT

- a. At Employer's expense, Employer shall have the right to audit Claims on Anthem's premises, during regular business hours and in accordance with Anthem's audit policy, which may be revised from time to time. A copy of the audit policy shall be made available to Employer upon request.
- b. If Employer elects to utilize a third-party auditor to conduct an audit pursuant to this Agreement and Anthem's audit policy, such auditor must be mutually acceptable to Employer and Anthem. Anthem will only approve auditors that are independent and objective and will not approve auditors paid on a contingency fee or other similar basis. Anthem reserves the right to charge a fee to Employer for expenditure of time by Anthem's employees in completing any audit which fee shall be reasonable, based on Anthem's actual cost of the services of employees completing the audit. An auditor or consultant must execute and indemnification agreement with Anthem pertaining to Anthem's Proprietary and Confidential Information prior to conducting an audit.
- c. Employer may conduct an audit once each calendar year and the audit may only relate to Claims processed during the current year or immediately preceding calendar year (the "Audit Period") and neither Employer nor anyone acting on Employer's or the Plan's behalf, shall have a right to audit Claims processed prior to the Audit Period. The scope of the audit shall be agreed to in writing by the Parties prior to the commencement of the audit.
- d. Employer shall provide to Anthem copies of all drafts, interim and/or final audit reports at such time as they are made available by the auditor or consultants to Employer. Any errors identified as the result of the audit shall be subject to Anthem's review and acceptance prior to initiating any recoveries of Paid Claims pursuant to Article 13 of this Agreement. Anthem reserves the right to terminate any audit being performed

by or for Employer if Anthem determines that the confidentiality of its information is not properly being maintained or if Anthem determines that Employer or auditor is not following Anthem audit policy.

- e. An audit performed pursuant to this Agreement shall be the final audit for the Audit Period and for any prior Audit Period unless otherwise agreed to in writing by the Parties; however, Claims may be re-audited if Employer is required to conduct the audit by a government agency with which it has a contractual arrangement.

### ARTICLE 13 - RECOVERY SERVICES

- a. Pursuant to the provisions of this Article 13(a), Anthem shall review Paid Claims processed under this Agreement (including during any Claims Runout Period) to determine whether such Claims have been paid accurately and identify recoveries that can be pursued. Employer will receive the entire amount of any recovery obtained on its behalf. In performing these recovery services, Anthem shall not be obligated to retain outside counsel or other third parties if Anthem's recovery efforts are not successful. The cost of these services provided by Anthem for recovery efforts under this Article 13(a) is included in Anthem's Administrative Services Fee, as set forth in Section 3(A) ("Base Administrative Services Fee") of Schedule A.
- b. Anthem may become aware of additional recovery opportunities by means other than reviewing Paid Claims processed under this Agreement. Employer grants Anthem the authority and discretion in those instances to do the following: (1) determine and take steps reasonably necessary and cost-effective to effect recovery; (2) select and retain outside counsel; (3) reduce any recovery obtained on behalf of the Plan by its proportionate share of the outside counsel fees and costs incurred during litigation or settlement activities to obtain such recovery; and (4) negotiate and effect any settlement of Employer's and Plan's rights by, among other things, executing a release waiving Employer's and Plan's rights to take any action inconsistent with the settlement.
- c. During the term of this Agreement and any applicable Claims Runout Period, Anthem may pursue payments to Members by any other person, insurance company or other entity on account of any action, claim, request, demand, settlement, judgment, liability or expense that is related to a Claim for Covered Services ("Subrogation Services"). Anthem shall charge Employer a fee provided in Schedule A to this Agreement ("Subrogation Fee"). Any subrogation recoveries shall be net of the Subrogation Fee. Subrogation Fees will not be assessed on subrogation recoveries until they are received by Anthem and credited to Employer.
- d. Anthem will engage third parties: (1) to conduct a review of Paid Claims processed under this Agreement and perform other recovery related services that are in addition to the standard recovery services provided under Article 13(a); and, (2) to conduct audits of Provider and Vendor contracts. The purpose of these services is to determine whether Paid Claims processed under this Agreement have been paid accurately and, if they have not been paid accurately, to pursue recoveries. If Anthem makes a recovery as a result of the services described in this Article 13(d), then Anthem shall receive a fee provided in Schedule A as compensation for its services, a portion of which shall be paid to third parties for their services, and Employer will receive the remaining recovery amount.
- e. In exercising its authority pursuant to Articles 13(a) through (d), Anthem shall determine which recoveries it will pursue, and in no event will Anthem pursue a recovery if it reasonably believes that the cost of the collection is likely to exceed the recovery amount or if the recovery is prohibited by law or an agreement with a Provider or Vendor. Anthem will not be liable for any amounts it does not successfully recover. Anthem shall retain any recoveries it obtains as a result of its recovery services or audits if the cost to administer the refund is likely to exceed the amount of the refund. Employer further understands and agrees that Anthem shall have authority to enter into a settlement or compromise on behalf of Employer and Plan regarding these recovery, subrogation and audit services, including, but not limited to, the right to reduce future reimbursement to Provider or Vendor in lieu of a lump sum settlement. Anthem may have contracts with Network Providers or Vendors or there may be judgments, orders, settlements, applicable laws or regulations that limit Anthem's right to make recoveries under certain circumstances. Anthem may, but is not required to, readjudicate Claims or adjust Members' cost share payments related to the recoveries made from a Provider or a Vendor. Anthem shall credit Employer net recovery amounts after deduction of fees and costs as set forth in this Article 13 not later than 150 days following the receipt of the total recovery amount. If Anthem does not credit Employer within 150 days of its receipt of the total recovery amount, Anthem shall pay Employer interest calculated at the Federal Reserve Funds Rate in

effect at the time of the payment. In no event, however, will Anthem be liable to credit Employer for any recovery after the termination date of this Agreement and any Claims Runout Period, and Employer acknowledges and agrees that such sums shall be retained by Anthem as reasonable compensation for recovery services provided by Anthem.

#### ARTICLE 14 - PHARMACY BENEFITS AND SERVICES

- a. If applicable to Plan benefits and as indicated in Schedule B of this Agreement, Anthem, through PBM, shall provide the following Prescription Drug management services:
  1. Anthem shall offer Employer access to a network of pharmacies that have entered into contractual arrangements with PBM under which such pharmacies agree to provide pharmacy services to Members and accept negotiated fees for such services ("Network Pharmacies"). **Anthem shall determine, in its sole discretion, which pharmacies shall be Network Pharmacies, and the composition of Network Pharmacies may change from time to time.**
  2. **Anthem will furnish and maintain a drug formulary for use with the Plan, and Anthem shall periodically review and update its formulary. The Employer shall adopt such formulary as part of the design of the Plan.** Unless mutually agreed to in writing by the Parties, upon termination of the Agreement, the Employer shall cease adoption and use of Anthem's formulary as part of its Plan. The drug formulary will be made available to Members on Anthem's web site and upon request may be provided to Employer in a mutually acceptable format for Employer's distribution to Members.
  3. Anthem shall offer Employer a home delivery pharmacy program, through which Members may receive home delivery prescription services. Additional fees for express mail, shipping or handling may be charged to Members. Anthem shall also offer Employer a specialty pharmacy program, through which Members may receive specialty pharmacy prescription services. Anthem shall provide all necessary information and forms to Members to obtain these services.
  4. Anthem shall arrange for the processing of Prescription Drug Claims in accordance with the Benefits Booklet.
- b. PBM has negotiated programs with pharmaceutical manufacturers under which rebates for certain Prescription Drugs dispensed to Members are made directly to PBM ("Drug Rebate Programs"). Such Drug Rebate Programs are not based on the drug utilization of any one Employer Plan, but rather are based on the drug utilization of all individuals enrolled in PBM managed programs. In many cases the rebates are conditioned on certain Prescription Drugs being included on the formulary that Anthem requires Employer to adopt as part of the Plan. PBM will pay Anthem a portion of the rebates it receives (such portion being referred to in this Agreement as "Drug Rebates"). Anthem shall pay Employer an amount attributable to its actual or estimated receipt of the Drug Rebates as described in Section 3(A) of Schedule A.
- c. Anthem may receive and retain administrative fees from PBM or directly from pharmaceutical manufacturers. In addition, Anthem may receive and retain service fees from pharmaceutical manufacturers for providing services (e.g., Provider and Member education programs that promote clinically appropriate and safe dispensing and use of Prescription Drugs). For purposes of this Agreement, administrative fees and service fees received by Anthem or PBM shall not be considered Drug Rebates.
- d. If Employer terminates the pharmacy benefits portion of its Plan with Anthem at any time, then Anthem shall have the right to amend the Base Administrative Services Fee indicated in Section 3(A) of Schedule A.

#### ARTICLE 15 - INTER-PLAN ARRANGEMENTS

This Article is intentionally omitted and replaced by the Inter-Plan Arrangements Schedule.

#### ARTICLE 16 - CLAIMS LITIGATION

- a. For purposes of Articles 16 and 17 of this Agreement, "Claims Litigation" means a demand asserted or litigation, proceedings or arbitration commenced, by a Member, Plan beneficiary or Network or non-Network

Provider, or any individual or entity working on any of their behalf ("Claimant(s)"), regardless of how pled or how asserted, where the Claimant seeks to recover monetary damages (including but not limited to actual, compensatory, punitive or other damages), equitable relief, declaratory relief, attorneys' fees, costs, expenses, or other relief, in connection with Anthem's alleged failure to properly handle a request for Covered Services or to pay for all or any portion of Covered Services, including any allegations related to the sufficiency of the amount paid for all or any portion of a Covered Service. References to "Employer" in this Article 16 shall mean Employer or Plan or both as appropriate given the context.

- b. Anthem shall direct the defense of any Claims Litigation brought against Anthem. If Employer (in addition to Anthem) is also a named party in the Claims Litigation, Anthem shall direct the defense of the Claims Litigation and the Employer will cooperate in defending against the Claims Litigation. Employer will direct the defense of the Claims Litigation where Anthem is not a named party. Unless there is a conflict that is not waived, in any of the above scenarios, if Anthem's requests, Anthem and the Employer will enter a common interest and/or joint defense agreement to address the sharing of information and any other matters the Parties deem appropriate. Whether there is such a conflict or not, all other provisions of this Article 16 will continue to apply. Anthem shall provide notice of Claims Litigation to the Employer as soon as practicable; provided, however, that this notice obligation shall not apply to Claims Litigation brought by any Provider or to any Claims Litigation to which Employer is a named party.
- c. For any Claims Litigation to which Anthem is a named party, Anthem will select and retain counsel for itself and, if Employer is also named, for the representation of Anthem and Employer contemplated by Article 16(b). If, at the outset or during such Claims Litigation, Employer and Anthem have a conflict of interest, the selected counsel shall represent Anthem only. Employer shall waive any conflict for such representation and retain separate counsel for Employer. Subject to Article 16(d), Employer will assume liability for payment of all reasonable attorneys' fees and costs incurred by Anthem and/or Employer in the defense of Claims Litigation.
- d. If it is determined by the third-party decision maker in the Claims Litigation that Anthem failed to perform its responsibility to review and determine Claims for benefits under the Plan in a manner that is consistent with the standard of care in Article 17 of this Agreement, Anthem will assume liability for payment of its legal fees and costs.
- e. Anthem is authorized to settle or compromise any Claims Litigation with the approval of Employer, which approval shall not be unreasonably withheld. Notwithstanding the above, **settlements of reimbursement disputes brought by Providers do not require the approval of Employer.**
- f. Anthem is not an insurer of benefits under the Plan nor does it underwrite the risk or otherwise assume any risk for the payment of benefits under the Plan. Under all circumstances, Employer shall be liable to pay Plan benefits awarded or paid by settlement, judgment, or otherwise.

#### ARTICLE 17 - INDEMNIFICATION

Except for Claims Litigation, which is governed exclusively by Article 16 of this Agreement, Anthem and Employer shall each indemnify, defend and hold harmless the other Party, and its directors, officers, employees, agents and affiliates, from and against any and all losses, claims, damages, liabilities, costs and expenses (including without limitation, reasonable attorneys' fees and costs) that are recovered in direct actions between the Parties or actions brought by a third party asserting liability for: (1) the indemnifying Party's or its subcontractor's gross negligence or willful misconduct in the performance of the obligations under this Agreement, and/or (2) the indemnifying Party's failure to provide information required under this Agreement or otherwise required by law that results in a sanction or penalty being assessed against the other Party, and/or (3) the indemnifying Party's or its subcontractor's breach of fiduciary duties under ERISA. The obligation to provide indemnification under this Agreement shall be contingent upon the Party seeking indemnification: (i) providing the indemnifying Party with prompt written notice of any claim for which indemnification is sought, (ii) allowing the indemnifying Party to control the defense and settlement of such claim; provided, however, that the indemnifying Party agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes any restrictions or obligations on an indemnified Party without that indemnified Party's prior written consent, which will not be unreasonably withheld; and, (iii) cooperating fully with the indemnifying Party in connection with such defense and settlement.



## ARTICLE 18 - CHANGES IN BENEFITS BOOKLET AND AGREEMENT

- a. Either Party reserves the right to propose changes to the provisions described in the Benefits Booklet by giving written notice to the other Party not less than 90 days prior to the start of an Agreement Period and such changes will be made to the Benefits Booklet as mutually agreed to in writing by the Parties. Either Party may also propose changes to the Benefits Booklet at a time other than the start of an Agreement Period and such changes will be made to the Benefits Booklet if mutually agreed to in writing by the Parties. Anthem's incorporation of the requested changes into the Benefits Booklet shall constitute Anthem's acceptance of the Employer's requested changes. If Anthem initiates the proposed changes and does not receive written notice from Employer prior to the effective date of the proposed changes that such changes are unacceptable, the changes shall be deemed approved by Employer and Anthem shall incorporate such changes into the Benefits Booklet.
- b. If changes to the provisions of the Benefits Booklet are mandated as a result of a change to any applicable state or federal law, Anthem shall have the right to make such changes to the Benefits Booklet to comply with the law and shall provide written notice to Employer at least 30 days prior to the effective date of the change, unless the effective date specified in the law is earlier.
- c. Anthem also reserves the right to change the Base Administrative Services Fee provided in Section 3(A) of Schedule A at a time other than the start of an Agreement Period upon the occurrence of one or more of the following events: (1) a change to the Plan benefits initiated by Employer that results in a substantial change in the services to be provided by Anthem; (2) a change in ownership as described in Article 3(h) of this Agreement; (3) a change in the total number of Members resulting in either an increase or decrease of 10% or more of the number of Members enrolled for coverage on the date the Base Administrative Services Fee was last modified; (4) a change in Employer contribution as described in Article 3(e) of this Agreement; (5) a change in nature of Employer's business resulting in a change in its designated Standard Industrial Classification ("SIC") code; or (6) a change in applicable law that results in a material increase in the cost or amount of administrative services from those currently being provided by Anthem under this Agreement. Anthem shall provide notice to Employer of the change in the Base Administrative Services Fee at least 60 days prior to the effective date of such change. If such change is unacceptable to Employer, either Party shall have the right to terminate this Agreement by giving written notice of termination to the other Party before the effective date of the change. If Employer accepts the proposed Base Administrative Services Fee, Anthem shall provide a revised Schedule A that will then become part of this Agreement without the necessity of securing Employer's signature on the Schedule.
- d. In the event any action of any department, branch or bureau of the federal, state or local government is initiated or taken ("Action") against a Party to this Agreement and such Action materially and adversely affects that Party's performance of the obligations under this Agreement, the affected Party shall notify the other Party of the nature of the Action and provide copies of pertinent documents supporting the reason(s) for the Action. If a modification to the Agreement is needed as a result of the Action, the Parties shall meet within 30 days of the notice by the affected Party to the other Party and shall, in good faith, attempt to negotiate a modification to this Agreement that minimizes or eliminates the impact of the Action. If the Parties are unable to minimize or eliminate the impact of the Action, then either Party may terminate this Agreement by giving at least 90 days notice of termination. This Agreement may be terminated sooner if agreed to by the Parties or required by the government entity initiating or taking the Action.
- e. No modification or change in any provision of this Agreement shall be effective unless and until approved in writing by an authorized representative of Anthem and evidenced by an amendment or new Schedule attached to this Agreement. If Anthem proposes such a modification or change, Anthem shall provide written notice to Employer at least thirty (30) days prior to the effective date of such change. The modification or change will be deemed accepted by Employer unless Anthem receives written notice from Employer prior to the effective date that such change is unacceptable. If Employer does not accept the proposed change, the Parties will meet and confer to reach agreement prior to implementation of such change.

## ARTICLE 19 - TERMINATION AND/OR SUSPENSION OF PERFORMANCE

- a. Notwithstanding any other provision of this Article, this Agreement automatically terminates, without further notice or action, if Employer fails to pay or fund any amount due under this Agreement within 7 days of the date of Anthem's notice to the Employer of a delinquent amount owed. Notwithstanding the foregoing, in the event of a bona fide dispute regarding an Administrative Service Fee charge, Anthem shall not

terminate this Agreement on the basis of the alleged delinquency pending the resolution of such dispute if the Employer pays all undisputed amounts when due. Such termination shall be effective as of the last period for which full payment was made. In addition, this Agreement automatically terminates, without further notice or action, at the end of each Agreement Period unless Anthem offers to renew this Agreement and Employer accepts such offer of renewal pursuant to Article 6 of this Agreement. Upon termination of this Agreement, Employer shall remain liable for all payments due to Anthem under the terms of this Agreement. Notwithstanding the above, Anthem has the right to suspend performance of its obligations under this Agreement if full payment is not made by the Invoice Due Date. Anthem shall have no obligation to pay any Claims under the Agreement until all required payments have been paid in full.

- b. If either Party fails to comply with any material duties and obligations under this Agreement other than payment of amounts due under this Agreement, the other Party shall have the right to: (1) terminate this Agreement by giving the non-compliant Party at least 60 days prior written notice of termination; or (2) upon written notice to the other Party, suspend performance of its obligations under this Agreement. Employer acknowledges and agrees that in the event it is the non-compliant Party, Anthem shall have no liability to any Member. Either Party, at its option, may allow the non-compliant Party to cure a breach of this Agreement and, upon acceptance in writing by that Party that a breach is cured, this Agreement may be reinstated retroactive to the date of the breach or suspension of performance. Notwithstanding any other provision of this Agreement, a Party may seek injunctive or other equitable relief from a court of competent jurisdiction should there be any unauthorized use or disclosure of Proprietary Information or Confidential Information by the other Party.
- c. If there shall occur any change in the condition (financial or otherwise) of Employer or an Employer Affiliate that, in the reasonable opinion of Anthem, has a material adverse effect upon the validity, performance, or enforceability of this Agreement, on the financial condition or business operation of Employer (or Employer Affiliate), or on the ability of Employer to fulfill its obligations under this Agreement, then Anthem shall have the right to require Employer to provide adequate assurance of future performance, which may include a payment of a cash deposit, letter of credit, or other method of assurance acceptable to Anthem. Examples of such a change could include, but would not be limited to the actual, or Anthem's reasonable anticipation of: (1) any voluntary or involuntary case or proceedings under bankruptcy law with respect to Employer or an Employer Affiliate; (2) any receivership, liquidation, dissolution, reorganization or other similar case or proceeding with respect to Employer or an Employer Affiliate; (3) any appointment of a receiver, trustee, custodian, assignee, conservator or similar entity or official for Employer or an Employer Affiliate; or (4) any assignment for the benefit of creditors or sale of all or substantially all of Employer's assets or a key Employer Affiliate's assets.

Any deposit amount shall be paid to Anthem within 30 days of the request or in such shorter time as agreed to by the Parties. The deposit amount shall not be paid with Plan assets, shall not be funded in any part by Member contributions, and shall not be paid from any segregated fund or from funds in which the Plan or any Member has a beneficial interest. The deposit amount shall be the property of Anthem, may be held in Anthem's general account, may be subject to satisfy the claims of Anthem's general creditors, and does not govern or limit the benefits available under the terms of the Plan. At the termination of this Agreement and designated Claims Runout Period, if any, the deposit amount, net of any outstanding fees or Claims amounts payable to Anthem, shall be returned to Employer. Any deposit amount returned to Employer under this Article 19(c) shall not include interest. Neither Employer, the Plan, nor any Member shall have any beneficial or legal ownership interest in any deposit amount paid pursuant to this Section.

If such further assurance is required by Anthem, Anthem may, at any time after the date of notice to Employer of such requirement, suspend performance of its obligations under this Agreement until the date of receipt by Anthem of such adequate assurance without being liable to the Employer, the Plan or any Member for such suspension. If such adequate assurance is not received within 30 days of the request, Anthem may terminate this Agreement.

- d. Subject to the provisions of Article 7 of this Agreement, if this Agreement terminates and Anthem makes payment of any Claim that would otherwise have been payable under the terms of this Agreement after the termination date, Employer shall be liable to reimburse Anthem for such Claim to the extent that the amounts have not already been paid by Employer. Employer also agrees to cooperate fully with Anthem in the coordination of pharmacy Claims with any successor pharmacy benefit manager.
- e. Employer may terminate this Agreement at any time other than at the end of an Agreement Period by giving Anthem 60 days written notice of its intent to terminate.

- a. No action by either Party alleging a breach of this Agreement may be commenced after the expiration of 3 years from the date on which the claim arose.
- b. Except to the extent preempted by ERISA or any other applicable provisions of federal law, this Agreement shall be governed by, and shall be construed in accordance with the laws of Virginia but without giving effect to that state's rules governing conflict of laws.

- a. Any notice or demand pursuant to Articles 19 and 22 of this Agreement shall be deemed sufficient when made in writing as follows: to Employer, by first class mail, personal delivery, or electronic mail or overnight delivery with confirmation capability, to its principal office shown upon the records of Anthem; to Anthem, by first class mail, personal delivery, electronic mail or overnight delivery with confirmation capability, to the designated Anthem sales representative.
- b. A notice or demand shall be deemed to have been given as of the date of deposit in the United States mail with postage prepaid or, in the case of delivery other than by mail, on the date of actual delivery at the appropriate address.



- a. Employer, on behalf of itself and its Members, hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between Employer and Anthem, that Anthem is an independent corporation operating under a license with BCBSA permitting Anthem to use the Blue Cross and Blue Shield Service Marks in Virginia and that Anthem is not contracting as the agent of BCBSA. Employer further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem shall be held accountable or liable to it for any of Anthem's obligations to Employer created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this Agreement.
- b. Anthem is providing administrative services only with respect to the portion of the Plan described in the Benefits Booklet. Anthem has only the authority granted it pursuant to this Agreement. Anthem is not the insurer or underwriter of any portion of the Plan. Anthem has no responsibility or liability for funding benefits provided by the Plan, notwithstanding any advances that might be made by Anthem. Employer retains the ultimate responsibility and liability for the benefits and expenses incident to the Plan, including the applicable taxes that might be imposed relating to the Plan.
- c. The Parties acknowledge that the portion of the Plan described in the Benefits Booklet is a self-funded plan and is not subject to state insurance laws or regulations.
- d. Employer shall confirm that sufficient amounts are available to cover Claims payments, the monthly Administrative Services Fees, and other fees or charges.

- a. The following documents will constitute the entire Agreement between the Parties: this Agreement, including any amendments and Schedules thereto, and the Benefits Booklet.
- b. This Agreement may be executed simultaneously in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.
- c. This Agreement supersedes any and all prior agreements between the Parties, whether written or oral, and other documents, if any, addressing the subject matter contained in this Agreement.
- d. If any provision of this Agreement is held to be invalid, illegal or unenforceable in any respect under applicable law, order, judgment or settlement, such provision shall be excluded from the Agreement and the balance of this Agreement shall be interpreted as if such provision were so excluded and shall be enforceable in accordance with its terms.

This Article is intentionally omitted in its entirety.

- a. Employer and Anthem are separate legal entities. Anthem is strictly an independent contractor. Nothing contained in this Agreement shall cause either Party to be deemed a partner, member, agent or representative of the other Party, nor shall either Party have the expressed or implied right or authority to assume or create any obligation on behalf of or in the name of the other Party through its actions, omissions or representations.
- b. Except as may be explicitly set forth in this Agreement, nothing herein shall be construed as an implied license by a Party to use the other Party's name, trademarks, domain names, or other intellectual property. Neither Party shall use the name, trademarks, domain names, or any other name or mark of the other Party in any press release, printed form, advertising or promotional materials or otherwise, without the prior

written consent of the other Party. In addition, Employer has no license to use the Blue Cross and/or Blue Shield trademarks or derivative marks (the "Brands") and nothing in the Agreement shall be deemed to grant a license to Employer to use the Brands. Any references to the Brands made by Employer in its own materials are subject to prior review and approval by Anthem.

- c. Nothing contained herein shall cause either Party to be deemed an agent for service of legal process for the other Party.
- d. Anthem or an Anthem Affiliate may enter into business arrangements with certain Network Providers and Anthem may have financial interest in such Network Providers through direct ownership, partnership, joint venture or other arrangements. The business arrangements may provide practice management or other services to Network Providers that are designed to promote a more effective and cost-efficient health care delivery system that emphasizes continuous improvement and increased patient access to high quality, cost-effective health care. Because of its ownership or financial interests in Network Providers, Anthem may share in the Network Provider's profits or other revenue. Any revenue received by Anthem in connection with these business arrangements shall be retained by Anthem.
- e. The Parties acknowledge that Anthem, in making decisions regarding the scope of coverage of services under the Benefits Booklet, is not engaged in the practice of medicine. Providers are not restricted in exercising their independent medical judgment by contract or otherwise and do not act on behalf of, or as agents for, Anthem or the Plan.
- f. In addition to any other provision providing for survival upon termination of this Agreement, the Parties' rights and obligations under Articles 10, 11, 12, 13, 16, 17, 19, 24, 25(a) and 25(c) shall survive the termination of this Agreement for any reason.
- g. Each Party shall comply with all laws and regulations applicable to their respective duties and obligations assumed under this Agreement.
- h. Anthem and Employer agree to the performance standards set forth in Schedule C Performance Guarantees Schedule.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by affixing the signatures of duly authorized officers.

Owens & Minor Medical, Inc.

HealthKeepers, Inc. and Anthem Health Plans of Virginia,  
Inc. dba Anthem Blue Cross and Blue Shield

By: _____	By: _____
Title: _____	Title: _____
Date: _____	Date: _____

**SCHEDULE A  
TO  
ADMINISTRATIVE SERVICES AGREEMENT  
WITH  
OWENS & MINOR MEDICAL, INC.**

This Schedule A shall govern the Agreement Period from June 1, 2017 through December 31, 2018. For purposes of this Agreement Period, this Schedule shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms and conditions of the Agreement including any prior Schedules, and this Schedule A, the terms and conditions of this Schedule A shall control.

**Section 1. Effective Date and Renewal Notice**

This Agreement Period shall be from 12:01 a.m. June 1, 2017 to the end of the day of December 31, 2018.

Paid Claims shall be processed pursuant to the terms of this Agreement when incurred and paid as follows:

Incurred from June 1, 2017 through December 31, 2018 and  
Paid from June 1, 2017 through December 31, 2018.

Anthem shall provide any offer to renew this Agreement at least 120 days prior to the end of an Agreement Period.

**Section 2. Broker or Consultant Base Compensation**

Medical

Broker or Consultant Fee is \$3.47 per Subscriber per month. Upon receipt of payment from Employer, Anthem shall remit payment to the broker or consultant designated by Employer.

**Section 3. Administrative Services Fees**

**A. Base Administrative Services Fee**

June 1, 2017 through May 31, 2018: Composite \$ 35.41 per Subscriber per month

June 1, 2018 through December 31, 2018: Composite \$ 36.55 per Subscriber per month

Prescription Drug Rebates: Anthem will pay to Employer 100% of the Drug Rebates collected from PBM and attributable to Employer's Plan subject to Anthem's timely receipt of payment and accompanying data from PBM. On a quarterly basis, Anthem shall credit Employer the Drug Rebates it has collected from PBM. Anthem shall have the right to collect from Employer any rebate amount that Anthem is required to pay PBM as a result of a pharmaceutical manufacturer audit or for any other reason. Anthem shall continue to provide Employer its share of the Drug Rebates under this provision until the termination of this Agreement and any applicable Claims Runout period. Anthem shall provide a final report of the Drug Rebates received attributable to Employer's Plan after the end of any applicable Claims Runout period.

Change to Base Administrative Services Fees. In addition to the provisions in Article 18(c), Anthem reserves the right to change the Base Administrative Services Fees upon the occurrence of any of the following events:

- Employer's Member to Subscriber ratio is not within +/-5% of 1.93
- Anthem is not the sole third party administrator for medical benefits under Employer's Plan
- Employer's enrollment is not within +/-10% of 4,042 Subscribers
- Employer moves any of the Plan Benefits administered under this Agreement to another third party administrator or public or private exchanges

**Multi-year Agreements:** Anthem has the right to charge a fee to Employer if Employer terminates the pharmacy benefits administered by Anthem prior to the end of the multi-year Agreement Period contained in this Agreement. If Employer terminates the pharmacy benefits administered by Anthem prior to the end of the multi-year Agreement Period, Employer shall pay to Anthem upon receipt of an invoice:

\$1.00 Per Subscriber per month multiplied by the monthly average number of Subscribers enrolled in the Plan for the time period that this multi-year Agreement remained in effect multiplied by the number of months remaining in the multi-year Agreement after Employer's termination of the Agreement.

**Pharmacy Benefits Administrative Services Fee.** Administrative Services Fees shall also include a fee that will be charged monthly for services related to pharmacy benefits management including, but not limited to, pharmacy mail services, clinical services, and customer services. Such fee is included in the Base Administrative Services Fees described in Section 3(A) of this Schedule A.

**Article 3(a) Retroactive Adjustments to Enrollment.**

Anthem shall credit Administrative Services Fees for each retroactive deletion up to a maximum of 60 days and shall charge Administrative Services Fees for each retroactive addition up to a maximum of 60 days.

**B. Health and Wellness Program Fees**

Integrated Imaging Bundle                      \$1.28 per Subscriber per month

Mobile Health Consumer                      \$0.65 per Subscriber Per Month

**C. Other Fees or Credits**

**Fee for Subrogation Services.** The charge to Employer is 25% of gross subrogation recovery, or, if outside counsel is retained, 15% of the net recovery after a deduction for outside counsel fees.

**Fee for Provider Audit Performed by External Vendors.** The charge to Employer is 25% of the amount recovered from Vendor audits of Provider activity, including but not limited to credit balance, hospital bill audits, DRG readmissions and high-cost drug audits.

**Fee for Overpayment Identification Provided by External Vendors.** The charge to Employer is 25% of the amount recovered from review of Claims and membership data to identify overpayments, including but not limited to COB, duplicates, contract compliance and eligibility.

**Fee for Collection Services Provided by External Vendors.** The charge to Employer is 25% of the amount recovered by a Vendor in collecting receivables.

**Fee for Independent Claims Review:** \$550.00 per independent review

**Traditional Network Savings Fee.** Employer agrees to pay an additional amount based on the difference between Billed Charges for Covered Services and the Traditional Provider Negotiated Amount. The "Traditional Provider Negotiated Amount" is the amount Anthem, an Anthem Affiliate and/or Host Blue is contractually obligated to pay a Traditional Provider under a negotiated fee schedule, before application of Member cost-share amounts, such as deductibles, copayments and coinsurance. Claims submitted by a Provider affiliated with the Employer shall not be included in this calculation. Prescription Drug Claims, Claims paid on a capitated basis and Payment Innovation Program payments are excluded from the fee calculation. This fee applies to certain Providers who are paid by Anthem, an Anthem Affiliate and/or Host Blue according to a Traditional Network fee schedule ("Traditional Provider"). The Traditional Network Savings Fee is equal to 50% per Claim.

**Non-Network Savings Fee.** When Anthem forwards a non-Network Provider Claim to Vendor to negotiate with the non-Network Provider, the Employer will pay a fee equal to 50% of the difference between the non-Network Provider's Billed Charges and the amount Anthem uses to calculate Plan liability for the Covered Service (the "Plan Liability Amount"). In the case of facility-based Provider Claims, Plan Liability Amount will be based on the negotiated rate; if negotiations are not successful, the Plan Liability Amount shall be determined using Vendor's Data iSight tool. In the case of professional Provider Claims, Plan Liability Amount will be based upon Vendor's negotiated rate, if applicable (in the absence of successfully negotiated Claims, there will be no fee charged as the amount will be determined by the local Blue plan). These Claims will not be included in any Performance Guarantee calculations.

**Medical Drug Rebates:** Anthem shall retain rebates it receives directly from pharmaceutical manufacturers for Claims for Prescription Drugs administered by Anthem and covered under the medical benefit portion of the Plan(s) ("Medical Drug Rebates") for its own use and as reasonable compensation for its services.

**Third Party Stop Loss Reporting Fee:** Employer will pay a fee of \$1.00 per Subscriber per month for generation of reports delivered to an external stop loss carrier. Confidentiality Agreements must be completed with the Employer and third party stop loss carrier prior to files being released.

**Fee for Ad Hoc Reports.** Anthem shall provide, on an annual basis, up to 20 hours of time needed to generate custom or ad hoc reports at no additional charge. The charge to Employer beyond 20 hours per year is \$150.00 per hour for time needed to generate custom or ad hoc reports.

**Fee for Electronic Data Feeds to an Outside Vendor.** Anthem shall provide, on an annual basis, up to 12 electronic data feeds to an outside vendor in Anthem's standard format. The charge to Employer is \$1,000.00 for each additional feed.

**Universal Credit.** Anthem shall provide a credit totaling \$18 per Subscriber enrolled on June 1, 2017 to Employer for use from June 1, 2017 through December 31, 2019 and forfeited if not used within 36 months following the effective date. Services from a vendor that is a direct competitor of Anthem are not eligible for reimbursement. Anthem will not reimburse Employer's vendors directly.

The credit can be used for the following purposes:

- Custom communication services provided by either Anthem or an outside vendor;
- Pre-implementation audit equal to actual billed charges;
- Implementation expenses;
- Claims audit equal to actual billed charges\*;
- Clinical audit equal to actual billed charges\*;
- Wellness programs purchased by Employer from Anthem; or
- Additional reporting or data feeds equal to the actual billed charges.

Personnel expenses, programming expenses and travel are not reimbursable. The Employer acknowledges and agrees that Anthem will report the payment or credit where required by law to do so.

**Employee Assistance Program (EAP):**

Basic Program (3 Face-to-Face Counseling Visits) \$1.05 per Subscriber Per Month

#### **Section 4. Paid Claims, Billing Cycle and Payment Method**

##### **A. Paid Claims**

Paid Claims are described in Article 1-Paid Claims Definition of the Agreement.

##### **B. Billing Cycle**

**Weekly**

Anthem shall notify Employer of the amount due to Anthem as a result of Claims processed and paid by Anthem according to the billing cycle described above. The actual date of notification of Paid Claims and the Invoice Due Date will be determined according to Anthem's regular business practices and systems capabilities.

**C. Payment Method**

ACH Demand Debit Reimbursement for Paid Claims. Anthem will initiate an ACH demand debit transaction that will withdraw the amount due from a designated Employer bank account no later than three (3) business days following the Invoice Due Date, however, if the Invoice Due Date falls on either a banking holiday, a Saturday or a Sunday, the withdrawal shall be made on the following banking day.

**Section 5. Administrative Services Fee Billing Cycle and Payment Method**

**A. Billing Cycle**

Monthly List Bill (pay as billed)

Anthem shall notify Employer of the amount due to Anthem pursuant to Section 3 of Schedule A according to the billing cycle described above. The actual date of notification of amounts due and the Invoice Due Date will be determined according to Anthem's regular business practices and systems capabilities.

**B. Payment Method**

ACH Demand Debit Reimbursement. Anthem will initiate an ACH demand debit transaction that will withdraw the amount due from a designated Employer bank account no later than three (3) business days following the Invoice Due Date, however, if the Invoice Due Date falls on either a banking holiday, a Saturday or a Sunday, the withdrawal shall be made on the following banking day.

**Section 6. Claims Runout Services**

**A. Claims Runout Period**

Claims Runout Period shall be for the 12 months following the date of termination of this Agreement.

**B. Claims Runout Administrative Services Fees**

Medical:

Claims Runout Administrative Services Fee will be equal to 6% of Claims processed and paid by Anthem or through Inter-Plan Arrangements if Employer terminates prior to 3 years from the effective date of the Agreement Period. A Claims Runout Administration Services Fee will not be charged if the Employer terminates at least 3 years after the effective date of the Agreement Period.

**Section 7. Inter-Plan Arrangements:**

All Inter-Plan Arrangement-related fees, including any Access Fees paid to Host Blues, the Administrative Expense Allowance ("AEA") Fee and any Negotiated Arrangement fees are included in Anthem's Base Administrative Services Fee. Other Inter-Plan Arrangement-related fees included in the Base Administrative Services Fee include the Central Financial Agency Fee, ITS Transaction Fee, Toll-Free Number Fee and, if applicable, Blue Cross Blue Shield Global Core Program Fees. If Employer requests printed Provider directories attributable to a Host Blue's service area, the fee that will be charged is dependent upon page length, number ordered and will include shipping, taxes and system maintenance costs.

**Blue Cross Blue Shield Global Core Fees** – Included in Base Administrative Services Fee.

**Section 8. Other Amendments. The Administrative Services Agreement is otherwise amended as follows:**

Not Applicable.

**SCHEDULE B  
TO  
ADMINISTRATIVE SERVICES AGREEMENT  
WITH  
OWENS & MINOR MEDICAL, INC.**

This Schedule B shall govern the Agreement Period from June 1, 2017 through December 31, 2018. For purposes of this Agreement Period, this Schedule B shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules and this Schedule B, the terms of this Schedule B shall control.

The following is a list of services that Anthem will provide under this Agreement for the Base Administrative Services Fee listed in Section 3(A) of Schedule A. These services will be furnished to Employer in a manner consistent with Anthem's standard policies and procedures for self-funded plans. Anthem may also offer services to Employer that have an additional fee. If Employer has purchased such services, those services and any additional fees are also listed in Schedule A.

**SERVICES INCLUDED IN THE BASE ADMINISTRATIVE SERVICES FEE IN SECTION 3A OF SCHEDULE A**

**Management Services**

- Anthem's Benefits and administration as described in this paragraph:
  - Anthem definitions, and exclusions
  - Employer-specific benefits and exclusions
  - Anthem complaint and appeals process (One mandatory level of appeal, one voluntary level of appeal)
  - Claims incurred and paid as provided in Schedule A
  - Accumulation toward plan maximums beginning at zero on effective date
  - Anthem Claim forms
  - ID card
  - Explanation of Benefits (Non-customized)
- Acceptance of electronic submission of eligibility information in HIPAA-compliant format
- Preparation of Benefits Booklet (accessible via internet)
- Information for ERISA 5500
- Account reporting - standard data reports
- Billing and banking services
- Plan Design consultation
- Employer eServices
  - Add and delete Members
  - Download administrative forms
  - View Member Benefits and request ID cards
  - View eligibility
  - View Claim status and detail
- Responsible Reporting Entity for the Plan
- Information for preparation of SBC

### **Claims and Customer Services**

- Claims processing services
- Coordination of Benefits
- Recovery services performed internally by Anthem
- Medicare crossover processing
- Employer customer service, standard business hours
- Member customer service, standard business hours
- 1099s prepared and delivered to Providers
- Residency-based assessments and/or surcharges and other legislative reporting requirements
- Member eServices
- Member identity theft and credit monitoring and identity repair
- Open enrollment meeting support
- Women's Health and Cancer Rights Act notices

### **Prescription Benefit Services**

- Home delivery pharmacy
- Specialty Pharmacy Services
- Prescription eServices
  - Pharmacy locator
  - Online formulary
- Point of sale claims processing
- Home delivery claims processing
- Home delivery call center with toll free number
- Home delivery regular shipping and handling
- Standard management reports
- Ad hoc reports (subject to additional programming charge if required)
- Concurrent Drug Utilization Review (DUR) programs
- Retrospective DURs
- Administrative override (i.e., vacation, lost, stolen or spilled medications)
- Clinical review
- Pharmacy help desk with toll free number
- Pharmacy audits (desk and onsite; routine, in depth or focused)



## **Care Management**

- Health Care Management
  - Referrals
  - Utilization management
  - Case management
  - Anthem Medical Policy
- SpecialOffers
- HealthCare Advisor
- Care Comparison (where available)
- Transplant services - Blues Distinction
- Healthy Solutions Newsletter (available online)
- MyHealth (Member Portal)
  - Electronic Health Risk Assessment
  - Personal Health Record
  - Online Communities
  - Member Alerts
- Health and Wellness Services (PPO Plan)
  - ConditionCare
    - Asthma
    - Pulmonary disease
    - Congestive heart failure
    - Coronary artery disease
    - Diabetes
  - Future Moms Maternity Program with Mailings
  - ComplexCare
  - 24/7 NurseLine
  - MyHealth Advantage -- Gold Level
  - Healthy Lifestyles Online
  - LiveHealth Online
  - Emergency Room Utilization Management (ERUMI)/Quick Care Options (QCO)
  - Oncology Solution
  - Utilization Review and Case Management (UR-CM)

### **Networks**

- Access to networks
  - Provider Network
  - Mental Health/Substance Abuse Network
  - Coronary Services Network
  - Human Organ and Tissue Transplant Network
  - Complex and Rare Cancer Network
  - Bariatric Surgery Network
- Network Management
- Online Provider directory
- Inter-Plan Arrangements

**SCHEDULE C  
TO  
ADMINISTRATIVE SERVICES AGREEMENT  
WITH  
OWENS & MINOR MEDICAL, INC.**

This Schedule C provides certain guarantees pertaining to Anthem's performance under the Agreement between the Parties ("Performance Guarantees") and shall be effective for the period from June 1, 2017 through December 31, 2018, unless otherwise specified herein (the "Performance Period"). Descriptions of the terms of each Performance Guarantee applicable to the Parties are set forth in the Attachments (the "Attachments") to this Schedule C and made a part of this Schedule C. This Schedule shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules and this Schedule C, the terms of this Schedule C shall control. If there are any inconsistencies between the terms contained in this Schedule, and the terms contained in any of the Attachments to this Schedule C, the terms of the Attachments to this Schedule C shall control. These Performance Guarantees are guaranteed upon offer and acceptance of renewal.

**Section 1. General Conditions**

- A. The Performance Guarantees described in the Attachments to this Schedule C shall be in effect only for the Performance Period indicated above, unless specifically indicated otherwise in the Attachments. Each Performance Guarantee shall specify a/an:
  1. Performance Category. The term Performance Category describes the general type of Performance Guarantee.
  2. Reporting Period. The term Reporting Period refers to how often Anthem will report on its performance under a Performance Guarantee.
  3. Measurement Period. The term Measurement Period is the period of time under which Anthem's performance is measured, which may be the same as or differ from the period of time equal to the Performance Period.
  4. Penalty Calculation. The term Penalty Calculation generally refers to how Anthem's payment will be calculated, in the event Anthem does not meet the target(s) specified under the Performance Guarantee.
  5. Amount at Risk. The term Amount at Risk means the amount Anthem may pay if it fails to meet the target(s) specified under the Performance Guarantee.
- B. Anthem shall conduct an analysis of the data necessary to calculate any one of the Performance Guarantees within the timeframes provided in the Attachments to this Schedule C. In addition, any calculation of Performance Guarantees, reports provided, or analysis performed by Anthem shall be based on Anthem's then current measurement and calculation methodology, which shall be available to Employer upon request.
- C. Any audits performed by Anthem to test compliance with any of the Performance Guarantees shall be based on a statistically valid sample size with a 95% confidence level.
- D. If the Parties do not have an executed Agreement, Anthem shall have no obligation to make payment under these Performance Guarantees.
- E. Unless otherwise specified in the Attachments to this Schedule C, the measurement of the Performance Guarantee shall be based on data that is maintained and stored by Anthem or its Vendors.
- F. If Employer terminates the Agreement between the Parties prior to the end of the Performance Period, or if the Agreement is terminated for non-payment, then Employer shall forfeit any right to collect any further payments under any outstanding Performance Guarantees, whether such Performance Guarantees are for a prior or current Measurement Period or Performance Period.

- G. Anthem reserves the right to make changes to any of the Performance Guarantees provided in the Attachments to this Schedule C upon the occurrence, in Anthem's determination, of either:
1. a change to the Plan benefits or the administration of the Plan initiated by Employer that results in a substantial change in the services to be performed by Anthem or the measurement of a Performance Guarantee; or
  2. an increase or decrease of 10% or more of the number of Subscribers that were enrolled for coverage on the latter of the effective date or renewal date of this Agreement.
- Should there be a change in occurrence as indicated above and these changes negatively impact Anthem's ability to meet the Performance Guarantees, Anthem shall have the right to modify the Performance Guarantees contained in the Attachments.
- H. For the purposes of calculating compliance with the Performance Guarantees contained in the Attachments to this Schedule C, if a delay in performance of, or inability to perform, a service underlying any of the Performance Guarantees is due to circumstances which are beyond the control of Anthem, or its Vendors, including but not limited to any act of God, civil riot, floods, fire, acts of terrorists, acts of war or power outage, such delayed or non-performed service will not count towards the measurement of the applicable Performance Guarantee.
- I. Some Performance Guarantees measure and compare year to year performance. The term Baseline Period refers to the equivalent time period preceding the Measurement Period.
- J. As determined by Anthem, Performance Guarantees may be measured using either aggregated data or Employer-specific Data. The term Employer-specific Data means the data associated with Employer's Plan that has not been aggregated with other employer data. Performance Guarantees will specify if Employer-specific Data shall be used for purposes of measuring performance under the Performance Guarantee.
- K. If any Performance Guarantees are tied to a particular program and its components, such Performance Guarantees are only valid if Employer participates in the program and its components for the entirety of the Measurement Period associated with the Performance Guarantee.

## **Section 2. Payment**

- A. If Anthem fails to meet any of the obligations specifically described in a Performance Guarantee, Anthem shall pay Employer the amount set forth in the Attachment describing the Performance Guarantee. Payment shall be in the form of a credit on Employer's invoice for Administrative Services Fees, which will occur annually unless otherwise stated in the Performance Guarantee.
- B. Notwithstanding the above, Anthem has the right to offset any amounts owed to Employer under any of the Performance Guarantees contained in the Attachments to this Schedule C against any amounts owed by Employer to Anthem under: (1) any Performance Guarantees contained in the Attachments to this Schedule C; (2) the Agreement; or, (3) any applicable Stop Loss Policy.
- C. Notwithstanding the foregoing, Anthem's obligation to make payment under the Performance Guarantees is conditioned upon Employer's timely performance of its obligations provided in the Agreement in this Schedule C, and the Attachments, including providing Anthem with the information or data required by Anthem in the Attachments. Anthem shall not be obligated to make payment under a Performance Guarantee if Employer or Employer's vendor's action or inaction adversely impacts Anthem's ability to meet any of its obligations provided in the Attachments related to such Performance Guarantee, which expressly includes but is not limited to Employer or its vendor's failure to timely provide Anthem with accurate and complete data or information in the form and format expressly required by Anthem.
- D. Where the Amount at Risk for a Performance Guarantee is on a percentage of a Per Subscriber Per Month (PSPM) fee basis, the Guarantee will be calculated by multiplying the PSPM amount by the actual annual enrollment during the Measurement Period.



**ATTACHMENT TO SCHEDULE C**  
**Performance Guarantees**  
**TO ADMINISTRATIVE SERVICES AGREEMENT**  
**WITH**  
**OWENS & MINOR MEDICAL, INC.**

**Operation Performance Guarantees**

This Attachment is made part of Schedule C and will be effective for the Performance Period from June 1, 2017 through December 31, 2018. This Attachment is intended to supplement and amend the Agreement between the Parties.

Additional Terms and Conditions:

- For purposes of imposing penalties, measurement shall not begin until the start of the fourth month of the initial Agreement period for the following measures: Claims Timeliness, Claims Financial Accuracy, Claims Accuracy, Average Speed of Answer, Call Abandonment Rate, and First Call Resolution
- Performance will be based on the results of a designated service team/business unit assigned to Employer, unless the guarantee is noted as measured with Employer-specific Data.

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
Implementation	6/1/2017-12/31/2018  2.5% of Base Admin. Services Fees	A minimum of 95% of all tasks will be completed by the dates specified in the implementation plan agreed to by the Parties.  The implementation plan will be developed by Anthem and will contain tasks to be completed by Employer and/or Anthem and a timeframe for completion of each task. The implementation plan will also contain Measurement Periods specific to each task. Anthem's payment under this Guarantee is conditioned upon Employer's completion of all designated tasks by the dates specified in the implementation plan.  This will be measured with Employer-specific Data.	<b>Result</b>	<b>Penalty</b>	<b>Measurement Period</b>
			95.0% or Greater	None	Defined in Implementation Plan
			90.0% to 94.9%	25%	
			85.0% to 89.9%	50%	
			Less than 85.0%	100%	<b>Reporting Period</b> 60 calendar days following the end of the implementation period
Implementation Survey	6/1/2017-12/31/2018  2.5% of Base Admin. Services Fees	A minimum average score of 3.0 will be attained on the Implementation Survey.  Anthem will prepare and send an Implementation Survey to Employer. Anthem will only consider survey results received within 30 calendar days from the delivery of the survey to the Employer.  This will be measured with Employer-specific Data.	<b>Average Number of Points</b>	<b>Penalty</b>	<b>Measurement Period</b>
			3.0 or Greater	None	Annual
			2.5 to 2.9	25%	
			2.0 to 2.5	50%	
			Less than 2.0	100%	<b>Reporting Period</b> 60 calendar days following Anthem's receipt of the survey
Claims Timeliness (14 Calendar Days)	2.0% of Base Admin. Services Fees	A minimum of 90% of Non-investigated medical Claims will be processed timely.  Non-investigated Claims are defined as medical Claims that process through the system without the need to obtain additional information from the Provider, Subscriber or other external sources. Processed Timely is defined as Non-investigated medical Claims that have been finalized within 14 calendar days of receipt.  This Guarantee will be calculated based on the number of Non-investigated Claims that Processed Timely divided by the total number of Non-investigated Claims.  The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter, Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented.  This will be measured with Employer-specific Data.	<b>Result</b>	<b>Penalty</b>	<b>Measurement Period</b>
			90.0% or Greater	None	Annual beginning with the start of the fourth month of the initial Agreement Period
			87.5% to 89.9%	25%	
			85.0% to 87.4%	50%	
			Less than 85.0%	100%	<b>Reporting Period</b> Annual

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
Claim Timeliness (30 Calendar Days)	2.0% of Base Admin. Services Fees	<p>A minimum of 98% of Non-investigated medical Claims will be processed timely.</p> <p>Non-investigated medical Claims are defined as Claims that process through the system without the need to obtain additional information from the Provider, Subscriber, or other external sources. Processed Timely is defined as Non-investigated medical Claims that have been finalized within 30 calendar days of receipt.</p> <p>This Guarantee will be calculated based on the number of Non-investigated Claims that Processed Timely divided by the total number of Non-investigated Claims.</p> <p>The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter, Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented.</p> <p>This will be measured with Employer-specific Data.</p>	Result	Penalty	Measurement Period
			98.0% or Greater	None	Annual beginning with the start of the fourth month of the initial Agreement Period
			95.0% to 97.9%	25%	
			92.0% to 94.9%	50%	
			Less than 92.0%	100%	Reporting Period Annual
Claims Financial Accuracy	1.0% of Base Admin. Services Fees	<p>A minimum of 99% of medical Claim dollars will be processed accurately.</p> <p>This Guarantee will be calculated based on the total dollar amount of audited medical Claims paid correctly divided by the total dollar amount of audited medical Paid Claims. The calculation of this Guarantee includes both underpayments and overpayments. The calculation of this Guarantee does not include Claim adjustments or Claims in any quarter in which an Employer requests changes to Plan benefits, until all such changes have been implemented.</p>	Result	Penalty	Measurement Period
			99.0% or Greater	None	Annual beginning with the start of the fourth month of the initial Agreement Period
			98.0% to 98.9%	25%	
			97.0% to 97.9%	50%	
			Less than 97.0%	100%	Reporting Period Annual
Claims Accuracy	1.0% of Base Admin. Services Fees	<p>A minimum of 97% of medical Claims will be paid or denied correctly.</p> <p>This Guarantee will be calculated based on the number of audited medical Claims paid and denied correctly divided by the total number of audited medical Claims paid and denied. The calculation of this Guarantee excludes in any quarter Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented.</p>	Result	Penalty	Measurement Period
			97.0% or Greater	None	Annual beginning with the start of the fourth month of the initial Agreement Period
			96.0% to 96.9%	25%	
			95.0% to 95.9%	50%	
			Less than 95.0%	100%	Reporting Period Annual
Open Enrollment ID Card Issuance	1.0% of Base Admin. Services Fees	<p>100% of ID cards will be mailed to Open Enrollment participants no later than the Employer's effective date provided that Anthem receives an accurate eligibility file.</p> <p>An Accurate Eligibility File is defined as (1) an electronic eligibility file formatted in a mutually agreed upon manner; (2) received by Anthem no later than 30 calendar days prior to the Employer's effective date; and, (3) contains an error rate of less than 1%.</p> <p>This will be measured with Employer-specific Data.</p>	Result	Penalty	Measurement Period
			100%	None	Employer's effective date  Reporting Period 60 calendar days following the Employer's effective date
			98.5% to 99.9%	\$100 per ID Card not to exceed 25% of amount at risk for this measure	
			97.0% to 98.4%	50%	
			Less than 97.0%	100%	

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
Ongoing ID Cards Issuance	1.0% of Base Admin. Services Fees	<p>A minimum of 99% of ongoing ID cards will be mailed to Members within 10 business days of Anthem's processing of an accurate eligibility file.</p> <p>An Accurate Eligibility File is defined as: (1) an eligibility file formatted in a mutually agreed upon manner; (2) received by Anthem outside of an open enrollment period; and, (3) contains an error rate of less than 1%. This Guarantee will be calculated based on the total number of ongoing ID cards mailed to Members within the timeframe set forth above divided by the total number of Members eligible to receive ongoing ID cards.</p> <p>This will be measured with Employer-specific Data.</p>	Result	Penalty	Measurement Period
			99.0% or Greater	None	Annual
			97.5% to 98.9%	25%	Reporting Period
			96.0% to 97.4%	50%	
Average Speed to Answer	1.0% of Base Admin. Services Fees	<p>The average speed to answer (ASA) will be 30 seconds or less.</p> <p>ASA is defined as the average number of whole seconds members wait and/or are in the telephone system before receiving a response from a customer service representative (CSR) or an interactive voice response (IVR) unit. This Guarantee will be calculated based on the total number of calls received in the customer service telephone system.</p>	Result	Penalty	Measurement Period
			30 seconds or less	None	Annual beginning with the start of the fourth month of the initial Agreement Period
			30 to 35 seconds	25%	
			35 to 39 seconds	50%	
Call Abandonment Rate	1.0% of Base Admin. Services Fees	<p>A maximum of 3.0% of member calls will be abandoned.</p> <p>Abandoned Calls are defined as member calls that are waiting for a customer service representative (CSR), but are abandoned before connecting with a CSR. This Guarantee will be calculated based on the number of calls abandoned divided by the total number of calls received in the customer service telephone system. Calls that are abandoned in less than 5 seconds will not be included in this calculation.</p>	Result	Penalty	Measurement Period
			3.0% or Less	None	Annual beginning with the start of the fourth month of the initial Agreement Period
			3.1% to 3.5%	25%	
			3.6% to 4.0%	50%	
First Call Resolution	1.0% of Base Admin. Services Fees	<p>A minimum of 85% of member calls will be resolved during the initial contact with no further follow up required.</p> <p>First Call Resolution is defined as member callers receiving a response to their inquiry during an initial contact with no further follow-up required. This Guarantee will be calculated based on the total number of members who receive a First Call Resolution divided by the total number of calls received into the customer service telephone system.</p>	Result	Penalty	Measurement Period
			85.0% or Greater	None	Annual beginning with the start of the fourth month of the initial Agreement Period
			82.5% to 84.9%	25%	
			80.0% to 82.4%	50%	
Member Satisfaction	1.0% of Base Admin. Services Fees	<p>A minimum average score of 90% will be attained on the service skills component of the member satisfaction survey.</p> <p>The survey is conducted within 48 hours of a member calling a customer service representative (CSR). Each member caller is asked to rate the CSR on 5 attributes using a 5 point scale. The response is scored based on the total number of attributes that a member caller rates as positive divided by the number of attributes for which the member caller provides an answer (Member Score). This Guarantee will be calculated by determining the average of all Member Scores.</p>	Result	Penalty	Measurement Period
			90.0% or Greater	None	Annual
			84.5% to 89.9%	25%	Reporting Period
			80.0% to 84.4%	50%	
			Less than 80.0%	100%	Annual



Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
Management Reports	1.0% of Base Admin. Services Fees	Standard automated reports will be made available to Employer by no later than 25 calendar days following the end of the month. The reports will include financial, utilization and clinical information. This will be measured with Employer-specific Data.	<b>Result</b>	<b>Penalty</b>	<b>Measurement Period</b>
			Reports are late 1 month	None	Annual
			Reports are late 2 months	25%	<b>Reporting Period</b>
			Reports are late 3 or more months	100%	Annual
Account Management Satisfaction	1.0% of Base Admin. Services Fees	A minimum average score of 3.0 will be attained on the Account Management Satisfaction Survey (AMSS). A minimum of 3 responses per Employer to the AMSS is required to base the score on Employer-specific responses only. If 3 responses are received from the Employer, an average score is calculated by adding the scores from each respondent divided by the total number of Employer respondents. If fewer than 3 responses are received, the score will be calculated as follows:  2 Employer responses: 2/3 of the score will be based on Employer-specific AMSS results and 1/3 of the score will be based on the aggregate score of all AMSS results received by the Account Management Team.  1 Employer- response: 1/3 of the score will be based on Employer-specific AMSS results and 2/3 of the score will be based on the aggregate score of all AMSS results received by the Account Management Team.  0 Employer responses: The score will be based on the aggregate score of all AMSS results received by the Account Management Team.	<b>Result</b>	<b>Penalty</b>	<b>Measurement Period</b>
			3.0 or higher	None	Annual
			2.5 to 2.9	25%	
			2.0 to 2.4	50%	<b>Reporting Period</b>
			Less than 2.0	100%	Annual
AHG Engagement by Customer Service	1% of Base Admin. Services Fees	A minimum of 85% of Eligible Contacts will have Member Engagement. Member Engagement is defined as coaching, education or Member direction from an AHG representative. This Guarantee will be calculated based on the number of Eligible Contacts with Member Engagement divided by the total number of contacts eligible for Member Engagement. Eligible Contacts include mobile chat, portal click-to-chat and phone contacts with an AHG representative. This will be measured with Employer-specific Data.	<b>Result</b>	<b>Penalty</b>	<b>Measurement Period</b>
			85% or Greater	None	Annual
			83% - 84.9%	25%	
			81% - 82.9%	50%	<b>Reporting Period</b>
			79% - 80.9%	75%	Annual
			Less than 79%	100%	

**ATTACHMENT TO SCHEDULE C  
Performance Guarantees  
TO ADMINISTRATIVE SERVICES AGREEMENT  
WITH  
OWENS & MINOR MEDICAL, INC.**

**Network Guarantees**

This Attachment to Schedule C Performance Guarantees is made part of Schedule C, shall be effective for the Performance Period from June 1, 2017 through May 31, 2018 and is intended to supplement and amend the Agreement between the Parties.

Additional Terms and Conditions:

- This Guarantee applies to following time periods: (Measurement Period)
  - Claims Incurred from June 1, 2017 through December 31, 2018 and Paid from June 1, 2017 and through December 31, 2018.
- This Guarantee excludes the total Claims Charges for any Member that exceeds \$250,000 in paid claims in the Measurement Period.
- This guarantee replaces in previous financial guarantees presented. Discount guarantees cannot be offered alongside Trend Guarantees.
- Anthem has the right in its sole and reasonable discretion to modify or terminate this Guarantee if any of the following conditions occur:
  - Anthem is no longer the sole administrator for Employer's Plan.
  - Employer fails to maintain at least an average enrollment of 4,038 Subscribers.
  - The geographic distribution of Subscribers changes by more than 5% in any state or 10% in total from the Employer census provided for purposes of establishing this Guarantee.
- As previously mentioned, a change to the Plan benefits or the administration of the Plan initiated by Employer that results in a substantial change in the services to be performed by Anthem or the measurement of a Performance Guarantee.

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
Network Provider Discount	30% of Base Admin. Services Fees	A minimum Network Provider Discount of 57%.	<b>Result</b>	<b>Penalty</b>	<b>Measurement Period</b>
		This Guarantee excludes the total Claims Charges for any Member that exceeds \$250,000 in paid claims in the Measurement Period.	57.0% or Greater	None	Annual*
		Eligible Claim Charges are defined as charges for Covered Services provided to Members enrolled in PPO Plans. Eligible Claim Charges will be based on Anthem primary Claims only and will not include charges related to Prescription Drug Claims, Inter-Plan Program fees, state surcharges, Anthem Provider payment innovation programs or services rendered outside the United States. Allowed Amount is defined as the amount paid by Anthem to PPO Network Providers on Eligible Claim Charges plus any Member Cost Shares.	56.0% to 56.9%	25%	*This period applies to Claims incurred from June 1, 2017 through May 31, 2018 and Paid from June 1, 2017 and through August 31, 2018.
			55.0% to 55.9%	50%	
			54.0% to 54.9%	75%	
			Less than 54.0%	100%	
		This Guarantee will be calculated by dividing the PPO Network Provider Allowed Amount by the PPO Network Provider Eligible Claim Charges. The resulting percentage shall be subtracted from 100% to determine the Network Provider Discount.			<b>Reporting Period</b> Annual
		This Guarantee will be calculated by dividing the PPO Network Provider Eligible Claim Charges less the Allowed Amount by the PPO Network Provider Eligible Claim Charges less Member cost shares.			
		Anthem has the right in its sole discretion to modify or terminate this Guarantee if any of the following conditions occur: <ul style="list-style-type: none"> <li>• Anthem is no longer the sole administrator for Employer's Plan</li> </ul>			

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
		<ul style="list-style-type: none"> <li>Employer fails to maintain at least an average enrollment of 4,038 Subscribers.</li> <li>The geographic distribution of Subscribers changes by more than 5% in any state or 10% in total from the Employer census provided for purposes of establishing this Guarantee.</li> </ul> <p>Only Claims submitted to a Blue Cross and/or Blue Shield licensee for processing and adjudication shall be considered for purposes of this Discount Guarantee.</p> <p>This will be measured with Employer-specific Data.</p>		

**ATTACHMENT TO SCHEDULE C  
Performance Guarantees  
TO ADMINISTRATIVE SERVICES AGREEMENT  
WITH  
OWENS & MINOR MEDICAL, INC.**

**Integrated Imaging Management Program**

This Attachment to Schedule C Performance Guarantees is made part of Schedule C, shall be effective for the Performance Period from June 1, 2017 through December 31, 2018 and is intended to supplement and amend the Agreement between the Parties.

**Additional Terms and Conditions**

- Employer will communicate with its employees about the Integrated Imaging Program using marketing materials provided by Anthem.
- Unless otherwise provided herein, Anthem's Integrated Imaging Program includes high tech imaging services assigned at Anthem's discretion and include services such as CT, MRI, PET, nuclear cardiology, echocardiography, arterial ultrasound, cardiac catheterization and coronary intervention.
- Employer will support the clinical appropriateness decisions and cost/quality initiatives made by Anthem.
- Identified Members are Members who are identified by Anthem as appropriate for inclusion in the measured population, the selection criteria for which may be modified from time to time.
- A Member Redirected Service is an authorization for an imaging service (CT or MRI) provided at a location that is high quality and overall comparable or lower cost than the location originally requested by the ordering Provider.
- Member Redirected Guidance is defined as information provided by Anthem regarding options for imaging services (CT or MRI) at locations that are high quality and overall comparable or lower cost than the location originally requested by the ordering Provider.
- Standard minimum enrolled Members required: 5,000 non-Medicare primary Members.
- Members who are Medicare-primary are not eligible for inclusion in calculations related to these Performance Guarantees.
- Employer shall provide the historical eligibility information and the historical medical and Prescription Drug Claims in the form and for the time frame required by Anthem followed by monthly refreshes of Claims and Prescription Drug data from third party payers other than Anthem, if needed. All data must be materially complete and in the agreed upon format. Failure by Employer to provide any data in the time frame and format required by Anthem will nullify the applicable Performance Guarantee.
- Anthem reserves the right to revise Performance Guarantees to reflect modifications and advances in medical standards and practices when such standards and practices become generally accepted.
- Where the Amount at Risk for any Performance Guarantee provided below is based on a Per Subscriber Per Month (PSPM) basis, said Performance Guarantees shall be calculated by multiplying the PSPM amount by the actual enrollment during the Agreement Period.

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
Member Redirected Guidance for CT and MRI Services	10% of Imaging Services Fees	<p>A minimum of 90% of Identified Members will receive an attempted outreach telephone call which will provide Member Redirected Guidance within 3 business days of a prior authorization approval for a CT or MRI service. This Guarantee only applies to CT and MRI services.</p> <p>This Guarantee will be calculated based on the total number of Identified Members who receive an attempted outreach telephone call which provides Member Redirected Guidance divided by the total number of Identified Members receiving a prior authorization approval for a CT or MRI service.</p> <p>This will be measured with Employer-specific Data.</p>	100% of Amount at Risk	<p><b>Measurement Period</b> Annual*</p> <p>*This Guarantee applies to CT and MRI services that receive prior authorization approval during the Measurement Period.</p> <p><b>Reporting Period</b> Annual</p>
Member Redirection for CT and MRI Services:	10% of Imaging Services Fees	<p>A minimum of 10% of Identified Members will receive a Member Redirected Service. This Guarantee only applies to CT and MRI services.</p> <p>This Guarantee will be calculated based on the total number of Identified Members who receive CT and MRI Member Redirected Guidance divided by the total number of Identified Members receiving a prior authorization approval for a CT or MRI Service.</p> <p>This will be measured with Employer-specific Data</p>	100% of Amount at Risk	<p><b>Measurement Period</b> Annual.*</p> <p>*This Guarantee applies to CT and MRI services that receive prior authorization approval during the Measurement Period.</p> <p><b>Reporting Period</b> Annual</p>

**ATTACHMENT TO SCHEDULE C**  
**Performance Guarantees**  
**TO ADMINISTRATIVE SERVICES AGREEMENT**  
**WITH**  
**OWENS & MINOR MEDICAL, INC.**

**EAP Performance Guarantee**

This Attachment is made part of Schedule C and will be effective for the Performance Period from June 1, 2017 through December 31, 2018. This Attachment is intended to supplement and amend the Agreement between the Parties.

Additional Terms and Conditions:

- Unless otherwise provided in the description of a Performance Guarantee in this attachment, the Performance Guarantees herein require 30 or more of Employer's Members being measured in order for Anthem to have an obligation to make a payment under such Performance Guarantee
- All Performance Guarantees in which Anthem will make outbound calls to Identified Members will exclude Identified Members whom Anthem cannot reach due to incorrect or invalid telephone numbers, including numbers where permission is required by law but not provided, or those Identified Members who have requested that Anthem not contact them.
- Anthem reserves the right to revise Performance Guarantees to reflect modifications and advances in medical standards and practices when such standards and practices become generally accepted.

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
EAP Average Speed to Answer	5% of EAP Fees	The average speed to answer (ASA) will be 30 seconds or less. ASA is defined as the average number of whole seconds members wait and/or are in the telephone system before receiving a response from a customer service representative (CSR). This Guarantee will be calculated based on the total number of calls answered by a CSR.	<b>Result</b>	<b>Penalty</b>	<b>Measurement Period</b>
			30 seconds or less	None	Annual
			31-33 seconds	25%	
			34-36 seconds	50%	
			37-39 seconds	75%	<b>Reporting Period</b>
			Greater than 40 seconds	100%	
EAP Call Abandonment Rate	5% of EAP Fees	A maximum of 3% of member calls will be abandoned. Abandoned Calls are defined as member calls that are waiting for a customer service representative (CSR), but are abandoned before connecting with a CSR. This Guarantee will be calculated based on the number of calls abandoned divided by the total number of calls received in the customer service telephone system.	<b>Result</b>	<b>Penalty</b>	<b>Measurement Period</b>
			3% or Less	None	Annual
			3.01% - 3.4%	25%	
			3.41% - 3.7%	50%	
			3.71% - 3.99%	75%	<b>Reporting Period</b>
			Greater than 4%	100%	
EAP Management Reports	5% of EAP Fees	Standard EAP reports will be made available to Employer by no later than 15 business days following the end of the month. The reports will include utilization information.  This will be measured with Employer-specific Data.	<b>Result</b>	<b>Penalty</b>	<b>Measurement Period</b>
			By day 15	None	Quarterly
			Over 15 days – once	25%	
			Over 15 days -2 times	50%	<b>Reporting Period</b>
			Over 15 days -3 times	75%	
			Over 15 days -4 times	100%	

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
EAP Network Access	5% of EAP Fees	A minimum of 90% of Members will have Member access. Member Access is defined as access to at least 1 Network Provider in the following geographic areas:  Urban: 10 miles Suburban: 20 miles Rural: 45 miles  Member Access will be established by running a GeoAccess Report based on criteria established by Anthem prior to the beginning of each Measurement Period.  This Guarantee will be calculated based on the results of a GeoAccess report run at the beginning of a Measurement Period based on criteria established by Anthem compared to the results of a GeoAccess Report run at the end of a Measurement Period using the same criteria. This Guarantee will not include vision, dental or pharmacy Providers.  This will be measured with Employer-specific Data.	<b>Result</b>	<b>Penalty</b>	<b><u>Measurement Period</u></b>
			90% or Greater	None	Annual
			87.5% - 89.9%	25%	
			85% - 87.4%	50%	
			82.5% - 84.9%	75%	<b><u>Reporting Period</u></b>
			Less than 82.5%	100%	Annual

**ATTACHMENT TO SCHEDULE C**  
**Performance Guarantees**  
**TO ADMINISTRATIVE SERVICES AGREEMENT**  
**WITH**  
**OWENS & MINOR MEDICAL, INC.**  
  
**Pharmacy Performance Guarantees**

This Attachment is made part of Schedule C and will be effective for the Performance Period from June 1, 2017 through December 31, 2018. This Attachment is intended to supplement and amend the Agreement between the **Parties**. These Performance Guarantees are guaranteed upon offer and acceptance of renewal of the medical portion of the Agreement.

Additional Terms and Conditions:

- Employer must implement Exclusive Specialty across all benefits, otherwise Retail dispensing fees will increase by \$0.10 per claim.

**Prescription Drug Rebate Guarantees**  
**Minimum Drug Rebates:**

(a) The Drug Rebates Employer receives from Anthem will not be less than the following amounts ("Total Drug Rebates Guarantee"):

**NON-SPECIALTY BRAND NAME PRESCRIPTION DRUGS**

- (1) An amount equal to the sum of \$64.91 (Yr1) \$78.12 (Yr2) \$97.19 (Yr3) per Paid Claim for Non-Specialty Brand Name Prescription Drugs dispensed at retail pharmacy Network Providers; plus
- (2) An amount equal to the sum of \$228.82 (Yr1) \$275.25 (Yr2) \$333.29 (Yr3) per Paid Claim for Non-Specialty Brand Name Prescription Drugs dispensed at home delivery Network Providers

**SPECIALTY BRAND NAME PRESCRIPTION DRUGS**

- (1) An amount equal to the sum of \$553.03 (Yr1) \$660.29 (Yr2) \$857.46 (Yr3) per Paid Claim for Specialty Brand Name Prescription Drugs dispensed at retail pharmacy Network Providers; plus
- (2) An amount equal to the sum of \$517.43 (Yr1) \$627.42 (Yr2) \$758.75 (Yr3) per Paid Claim for Specialty Brand Name Prescription Drugs dispensed at home delivery Network Providers

This Guarantee will be determined by comparing the Total Drug Rebates Guarantee to the Drug Rebates credited to the Employer pursuant to Article 14 of the Agreement and Section 3(A) of Schedule A. If the Total Drug Rebates Guarantee exceeds the Drug Rebates credited to the Employer, Anthem will credit Employer the difference.

Any payment due to Employer under a Rebate Guarantee will not be offset by favorable results achieved in any other Rebate Guarantee. Any payment due to Employer under this Guarantee will not be offset by favorable results achieved in the Prescription Drug Pricing Guarantee, nor will it be offset by favorable results achieved in the Generic Dispensing Rate Guarantee.

This will be measured with Employer-specific data.

- (b) In addition to the provisions contained in Section 1(F) of Schedule C, Anthem reserves the right to make changes to this Guarantee upon the occurrence, in Anthem's determination, of any of the following:
  - a failure by Employer to implement its responsibilities under the clinical management programs that are part of the Plan or a failure by Employer to participate throughout the Measurement Period in any clinical management programs listed in Schedule B of this Agreement;
  - a failure by Employer to adopt the Formulary;
  - a change in the proportionate mix of Employer's retail and home delivery Prescription Drug Claims of more than 10%;
  - a change in pharmacy utilization patterns of more than 10%;
  - a change that results in Anthem no longer being the exclusive source of Drug Rebates for Employer's Plan; or
  - the determination that Employer has an on-site pharmacy with 340b designation or any such designation where the pharmacy receives upfront pricing discounts from pharmaceutical manufacturers, which was not disclosed or known by Anthem as of the effective date of this Attachment to Schedule C.
- Anthem is no longer the sole administrator for Employer's Prescription Drug Plan





## Prescription Drug Pricing Guarantees

### Prescription Drug Pricing:

(a) The Prescription Drug Pricing Guarantees for Ingredient Cost Discount and Dispensing Fees will be the amounts listed under the following Pricing Guarantee Categories:

#### RETAIL PHARMACY NETWORK PROVIDERS

The Guarantees for retail pharmacy Network Providers will be the following amounts:

1. Brand Discount: AWP minus 17.40% (Yr1) 17.40% (Yr2) 17.40% (Yr3)
2. Brand Dispensing Fee: \$0.70 (Yr1) \$0.70 (Yr2) \$0.70 (Yr3)
3. Generic Discount: AWP minus 79.20% (Yr1) 79.45% (Yr2) 79.70% (Yr3)
4. Generic Dispensing Fee: \$0.70 (Yr1) \$0.70 (Yr2) \$0.70 (Yr3)
5. Overall Specialty Drugs Discount: AWP minus 16.95% (Yr1) 16.95% (Yr2) 16.95% (Yr3)
6. Overall Specialty Drugs Dispensing Fee: \$2.00 (Yr1) \$2.00 (Yr2) \$2.00 (Yr3)

#### RETAIL 90 PHARMACY NETWORK PROVIDERS

The Guarantees for retail pharmacy Retail 90 Network Providers dispensing 84-90 day supplies will be the following amounts:

1. Brand Discount: AWP minus 19.50% (Yr1) 19.50% (Yr2) 19.50% (Yr3)
2. Brand Dispensing Fee: \$0.35 (Yr1) \$0.35 (Yr2) \$0.35 (Yr3)
3. Generic Discount: AWP minus 79.20% (Yr1) 79.45% (Yr2) 79.70% (Yr3)
4. Generic Dispensing Fee: \$0.35 (Yr1) \$0.35 (Yr2) \$0.35 (Yr3)

#### HOME DELIVERY PHARMACY

The Guarantees for home delivery will be the following amounts:

1. Brand Discount: AWP minus 24.25% (Yr1) 24.25% (Yr2) 24.25% (Yr3)
2. Brand Dispensing Fee: \$0.00 (Yr1) \$0.00 (Yr2) \$0.00 (Yr3)
3. Generic Discount: AWP minus 83.30% (Yr1) 83.55% (Yr2) 83.80% (Yr3)
4. Generic Dispensing Fee: \$0.00 (Yr1) \$0.00 (Yr2) \$0.00 (Yr3)
5. Overall Specialty Drugs Discount: AWP minus 16.95% (Yr1) 16.95% (Yr2) 16.95% (Yr3)
6. Overall Specialty Drugs Dispensing Fee: \$0.00 (Yr1) \$0.00 (Yr2) \$0.00 (Yr3)

To determine any payment due to Employer under these Prescription Drug Pricing Guarantees, each Guarantee is calculated based on the Prescription Drugs that were paid during the Measurement Period for Retail Pharmacy, Home Delivery, and Retail 90 Pharmacy (each such subset of Paid Claims is referred to as a "Pricing Guarantee Category"). Each Guarantee within a Pricing Guarantee Category is then compared to the sum of appropriate portion of the Paid Claims for Prescription Drugs plus any Member cost shares associated with each Guarantee within that Pricing Guarantee Category. Paid Claims for Prescription Drugs include Ingredient Costs plus Dispensing Fees. Therefore, Paid Claims for Prescription Drugs dispensed by a retail pharmacy are separated into Brand and Generic Ingredient Costs and Brand and Generic Dispensing Fees. These Ingredient Costs and Dispensing Fees are compared against each identified Guarantee provided in this Agreement to determine if the Guarantee is met. Any payment due to Employer under any Guarantee within a Pricing Guarantee Category will not be offset by: (i) favorable results achieved in any other Guarantee within that same Pricing Guarantee Category, (ii) overall favorable results for a Pricing Guarantee Category; or (iii) any Rebate Guarantee or Generic Dispensing Rate Guarantee. This will be measured with Employer-specific data.

(b) The following conditions apply to this Guarantee:

- This Guarantee applies to Claims submitted by Network Providers applicable to Employer's Plan.
- The following Claims will be excluded from this Guarantee:
  - Medicare Part D Claims
  - Vaccines;
  - Prescriptions filled through the Employer's on-site pharmacy;
  - Claims paid on the basis of U&C charges;
  - Compound Drugs;
  - Over-the-counter drugs;
- This Guarantee applies only as long as there are at least 78,000 Annualized Adjusted Prescription Drug Claims.
- Drugs identified at the time the prescription is filled as Single Source Generics, will be included in the Generic Discount and Generic Dispensing Fee Guarantees.

• Drugs identified at the time the prescription is filled as Dispensed As Written Claims with code 3, 4, 5, 6, 9 will be included in the Generic Discount and Generic Dispensing Fee Guarantees.

(c) In addition to the provisions contained in Section 1(F) of Schedule C, Anthem reserves the right to make changes to this Guarantee upon the occurrence, in Anthem's determination, of any of the following:

- a change in the proportionate mix of Employer's retail and home delivery Prescription Drug Claims of more than 10%;
- a change in pharmacy utilization patterns of more than 10%; or
- the determination that Employer has an on-site pharmacy with 340b designation or any such designation where the pharmacy receives upfront pricing discounts from pharmaceutical manufacturers, which was not disclosed or known by Anthem as of the effective date of this Attachment to Schedule C.
- Anthem is no longer the sole administrator for Employer's Prescription Drug Plan

In the event that there are court or government imposed or industry wide or pricing source initiated changes in the AWP reporting source or source changes in the methodology used for calculating AWP, including, without limitation, changes in the mark-up factor used in calculating AWP (collectively, the "AWP Changes"), the terms of any financial relationship between the Parties that relate to AWP will be modified by Anthem such that the value of AWP for the purpose of such relationship(s) will have the same economic equivalence in the aggregate to the value used by the Parties prior to the AWP Change. The intent of this provision is to preserve the relative economics of both Parties for such financial relationships based upon AWP to that which existed immediately prior to the AWP Change.

In the event that the AWP pricing benchmark used by Anthem's PBM hereunder is replaced with another benchmark calculation, Anthem may switch to such new pricing benchmark. If a change to pricing guarantees is deemed necessary Anthem will provide written notice of new pricing terms at least 30 days before the effective date of the change.

(d) For purposes of these Guarantees, the following terms have the following meanings:

- Average Wholesale Price or AWP is the price of a prescription drug dispensed as established and reported by MediSpan or other nationally recognized pricing source selected by PBM in its sole discretion from time to time. AWP does not represent a true wholesale price, but rather is a fluctuating benchmark provided by third party pricing sources.
- Brand Name Prescription Drug or Brand Drug is a Prescription Drug product that is not a Generic Drug.
- Compound Drug is a mixture of two or more ingredients when at least one of the ingredients in the preparation is an FDA-approved Prescription Drug, excluding the addition of only water or flavoring to any preparation.
- Dispensing Fee is the amount paid by Employer to Anthem for professional services rendered by a licensed pharmacist in dispensing Prescription Drugs.
- Dispense As Written Claims With Code 3 are Claims where a Brand Drug was dispensed when a Generic Drug is available, because the pharmacist selected the Brand Drug.
- Dispense As Written Claims With Code 4 are Claims where a Brand Drug was dispensed when a Generic Drug exists, because the Generic Drug was not in stock.
- Dispense As Written Claims With Code 5 are Claims where a Brand Drug was dispensed when a Generic Drug is available, because the pharmacy dispensed the Brand Drug at the Generic Drug cost (also known as House Generic Claims).
- Dispensed As Written Claims With Code 6 are Claims where a Brand Drug was dispensed when a Generic Drug is available, because of an override.
- Dispense As Written Claims With Code 9 are Claims where a Brand Drug was dispensed when a Generic Drug is available, because of other non-specified reason.
- Generic Prescription Drug or Generic Drug is a Prescription Drug, whether identified by its chemical, proprietary, or non-proprietary name that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.
- Ingredient Cost is the ingredient cost portion of a Paid Claim for Prescription Drugs.

- Most Favored Nations Limitations are government restrictions that preclude pharmacies from making pricing agreements with PBMs or others that are more favorable than those afforded to state-run programs, such as Medicaid.
- Single Source Generics are those Generic Drugs which are provided by two or fewer Pharmaceutical Manufacturers or such Generic Drugs that are in the market with supply limitations or competitive restrictions.
- Specialty Drugs are drugs dispensed from a Specialty Service Pharmacy or high-cost, injected, infused, oral, or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty Drugs may have special handling, storage, and shipping requirements, such as temperature control. Specialty Drugs may require nursing services or special programs to encourage patient compliance.
- Specialty Service Pharmacy is the PBM-owned or contracted specialty pharmacy that primarily dispenses Specialty Drugs, outside of the retail pharmacy Network and home delivery pharmacy.
- Usual and Customary (U&C) Charge is the amount a cash paying customer pays a pharmacy for a Prescription Drug. PBM shall require network pharmacies to submit the Usual and Customary Charges with all Claim submissions.
- Annualized Adjusted Prescription Drug Claims is the annualized sum of the total number of: (i) retail Prescription Drug Claims; (ii) home delivery Prescription Drug Claims multiplied by a factor of 3; and (iii) Specialty Prescription Drug Claims.

#### **Generic Dispensing Rate Guarantee**

(a) The Generic Dispensing Rate Employer receives from Anthem will not be less than the following amounts:

#### GENERIC PRESCRIPTION DRUGS RETAIL AND HOME DELIVERY PHARMACY

A minimum of 87.50% (Yr1) 88.00% (Yr2) 88.50% (Yr3) of retail drugs and a minimum of 78.00% (Yr1) 78.75% (Yr2) 79.50% (Yr3) of home delivery drugs will be dispensed as Generic Drugs.

Generic Dispensing Rate is defined as the total number of Generic Prescription Drug Claims received by Anthem divided by the total number of Prescription Drug Claims received by Anthem.

Any penalty owed for this Guarantee will be calculated as follows: Anthem shall determine the total Ingredient Cost for Generic Prescription Drugs and Brand Name Prescription Drugs by adding the Ingredient Cost for Brand Name Prescription Drugs and the Ingredient Cost for Generic Prescription Drugs. Anthem shall determine the total number of Claims received by Anthem for Brand Name Prescription Drugs and Generic Prescription Drugs. Anthem shall determine the average cost per Generic Prescription Drug by dividing the total Ingredient Cost for Generic Prescription Drugs by the total number of Generic Prescription Drug Claims received by Anthem. Anthem shall determine the average cost per Brand Name Prescription Drug by dividing the total brand Ingredient Cost by the total number of Brand Name Prescription Drug Claims received by Anthem.

Anthem shall then recalculate the total Ingredient Cost for Brand Name Prescription Drugs and Generic Prescription Drugs by multiplying the target guarantee percentages separately by the total number of Brand Name Prescription Drugs and Generic Prescription Drug claims received by Anthem which is then multiplied separately by the average Ingredient Cost per Brand Name Prescription Drug and the average Ingredient Cost per Generic Prescription Drug. The resulting difference in Ingredient Cost and the recalculated total Ingredient Cost is the penalty up to an annual maximum payout of \$200,000.00.

Any payment due to Employer under this Guarantee will not be offset by any favorable results achieved in the Prescription Drug Pricing Guarantee, nor will it be offset by favorable results achieved in the Minimum Drug Rebates Guarantee. Any payment due to Employer under these Generic Dispensing Rate Guarantees will not be offset by favorable results achieved in any other Generic Dispensing Rate Guarantees.

This will be measured with Employer-specific data.

(b) The following conditions apply to this Guarantee:

- Employer must have a 3-tier benefit structure for Prescription Drugs, and a minimum \$25 copay differential between Generic Prescription Drugs and Preferred Brand Name Prescription Drugs, and a \$15 copay differential between Preferred Brand Name Prescription Drugs and Non-Preferred Brand Name Prescription Drugs.
- Employer must implement generic management clinical programs as recommended by Anthem.
- Employer cannot make any benefit changes that result in disadvantaging the use of Generic Prescription Drugs.
- Client must include Member pay difference logic for Brand Name Prescription Drugs that offer an AB rated equivalent Generic Prescription Drug.

(c) In addition to the provisions contained in Section 1(F) of Schedule C, Anthem reserves the right to make changes to this Guarantee upon the occurrence, in Anthem's determination, of any of the following:

- a change in the proportionate mix of Employer's retail and home delivery Prescription Drug Claims of more than 10%;
- a change in pharmacy utilization patterns of more than 10%; or
- the determination that Employer has an on-site pharmacy with 340b designation or any such designation where the pharmacy receives upfront pricing discounts from pharmaceutical manufacturers, which was not disclosed or known by Anthem as of the effective date of this Attachment to Schedule C.
- Anthem is no longer the sole administrator for Employer's Prescription Drug Plan

(d) For purposes of these Guarantees, the following terms have the following meanings:

- Brand Name Prescription Drug or Brand Drug is a Prescription Drug product that is not a Generic Drug.
- Formulary is a list of preferred Prescription Drugs and medical supplies developed, published, and periodically revised by Anthem.
- Generic Prescription Drug or Generic Drug is a Prescription Drug, whether identified by its chemical, proprietary, or non-proprietary name that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.
- Ingredient Cost is the ingredient cost portion of a Paid Claim for Prescription Drugs.
- Non-Preferred Brand Name Prescription Drug is a Brand Name Prescription drug that is not included in the Formulary.
- Preferred Brand Prescription Drug is a Brand Name Prescription Drug that is included in the Formulary.

Pharmacy Access	2% of Rx Administration Fee	<p>Anthem will meet all of the following minimum criteria: (1) 98% of Members in urban areas will have 1 pharmacy Network Provider within 3 miles of their residence; (2) 98% of Members in suburban areas will have 1 pharmacy Network Provider within 5 miles of their residence; and, (3) 96% of Members in rural areas will have a pharmacy Network Provider within 10 miles of their residence. The obligation contained in this Guarantee is contingent upon a pharmacy existing within the GeoAccess Report standard.</p> <p>This Guarantee will be calculated based on the results of a GeoAccess report.</p> <p>Anthem has the right in its sole discretion to modify or terminate this Guarantee if Employer adopts a limited network of pharmacies.</p> <p>This will be measured with Employer-specific Data.</p>	100% of Amount at Risk	
Point-of-Sale Adjudication System Availability	1% of Rx Administration Fee	The point-of-sale adjudication system will be available a minimum of 99.8% of the time, excluding any scheduled system down time.	100% of Amount at Risk	<p><b><u>Measurement Period</u></b> Annual</p> <p><b><u>Reporting Period</u></b> Quarterly</p>
Point-of-Sale Adjudication System Response Time	1% of Rx Administration Fee	The average response time for the point-of-sale adjudication system will be within 2 seconds, excluding any scheduled system down time.	100% of Amount at Risk	<p><b><u>Measurement Period</u></b> Annual</p> <p><b><u>Reporting Period</u></b> Quarterly</p>
Retail Electronic Claims Processing Accuracy	1% of Rx Administration Fee	<p>99% of retail Claims will be processed without payment errors.</p> <p>This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies.</p>	100% of Amount at Risk	<p><b><u>Measurement Period</u></b> Annual</p> <p><b><u>Reporting Period</u></b> Quarterly</p>
Home Delivery Dispensing Accuracy	1% of Rx Administration Fee	<p>A minimum of 99.98% of home delivery Prescription Drug Claims will be dispensed without form, drug, dose or patient errors.</p> <p>This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies</p>	100% of Amount at Risk	<p><b><u>Measurement Period</u></b> Annual</p> <p><b><u>Reporting Period</u></b> Quarterly</p>

Home Delivery Pharmacy Claim Timeliness – Claims Not Requiring Intervention	1% of Rx Administration Fee	<p>A minimum of 99% of Home Delivery Pharmacy Claims Not Requiring Intervention (Investigation) will be processed within an average of 2 business days of receipt of a valid prescription. Home Delivery Pharmacy Claims Not Requiring Intervention are defined as Home Delivery Pharmacy Claims that process through the system without the need to obtain additional information from the Provider, Subscriber or other external sources to process the Home Delivery Pharmacy Claim.</p> <p>This Guarantee will be calculated based on the number of [Employer's] Home Delivery Pharmacy Claims Not Requiring Intervention processed within 2 business days divided by the total number of [Employer's] Home Delivery Pharmacy Claims Not Requiring Intervention. The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented.</p> <p>This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies.</p> <p>This will be measured with Employer-specific Data.</p>	100% of Amount at Risk	
Home Delivery Pharmacy Claim Timeliness – Claims Requiring Intervention	1% of Rx Administration Fee	<p>A minimum of 98% of Home Delivery Pharmacy Claims Requiring Intervention (Investigation) will be processed within an average of 5 business days of receipt of a valid prescription. Home Delivery Pharmacy Claims Requiring Intervention are defined as Home Delivery Pharmacy Claims that need additional information from the Provider, Subscriber or other external sources to process the Home Delivery Pharmacy Claim.</p> <p>This Guarantee will be calculated based on the number of [Employer's] Home Delivery Pharmacy Claims Requiring Intervention processed within 5 business days divided by the total number of [Employer's] Home Delivery Pharmacy Claims Requiring Intervention. The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented.</p> <p>This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies.</p> <p>This will be measured with Employer-specific Data.</p>	100% of Amount at Risk	<p><b><u>Measurement Period</u></b> Annual</p> <p><b><u>Reporting Period</u></b> Quarterly</p>
Home Delivery Claims Processing Accuracy	1% of Rx Administration Fee	<p>99% of Home Delivery Claims will be processed without payment errors. This Guarantee will be calculated based on the number of Home Delivery Pharmacy Claims paid correctly divided by the total number of Home Delivery Pharmacy Claims paid.</p> <p>This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies.</p>	100% of Amount at Risk	<p><b><u>Measurement Period</u></b> Annual</p> <p><b><u>Reporting Period</u></b> Quarterly</p>



Home Delivery Customer Service – Call Abandonment Rate	1% of Rx Administration Fee	<p>The call abandonment rate for Home Delivery Customer Service will be 3% or less of all member calls during normal business hours.</p> <p>Abandoned Calls are defined as member calls that are waiting for a customer service representative (CSR), but are abandoned before connecting with a CSR. This Guarantee will be calculated based on the number of calls abandoned divided by the total number of calls received in the customer service telephone system.</p> <p>This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies.</p> <p>This will be measured with Employer-specific Data.</p>	100% of Amount at Risk	<p><b><u>Measurement Period</u></b> Annual</p> <p><b><u>Reporting Period</u></b> Quarterly</p>
Home Delivery Customer Service – Average Speed of Answer (ASA)	1% of Rx Administration Fee	<p>97% of all Home Delivery Customer Service calls will be answered within an average speed to answer (ASA) of 30 seconds or less.</p> <p>ASA is defined as the average number of whole seconds members wait and/or are in the telephone system before receiving a response from a customer service representative (CSR) or an interactive voice response (IVR) unit. This Guarantee will be calculated based on the total number of calls received in the customer service telephone system.</p> <p>This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies.</p> <p>This will be measured with Employer-specific Data.</p>	100% of Amount at Risk	<p><b><u>Measurement Period</u></b> Annual</p> <p><b><u>Reporting Period</u></b> Quarterly</p>
Retail Paper Claims Turnaround Time – Claims Not Requiring Intervention	1% of Rx Administration Fee	<p>Retail Paper Claims Not Requiring Intervention will be processed within an average of 5 business days.</p> <p>Claims Not Requiring Intervention (Investigation) are defined as Pharmacy Claims that process through the system without the need to obtain additional information from the Provider, Subscriber or other external sources.</p> <p>This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies.</p>	100% of Amount at Risk	
Retail Paper Claims Turnaround Time – Claims Requiring Intervention	1% of Rx Administration Fee	<p>Retail Paper Claims Requiring Intervention will be processed within an average of 10 business days.</p> <p>Claims Requiring Intervention (Investigation) are defined as Pharmacy Claims that process through the system with the need to obtain additional information from the Provider, Subscriber or other external sources.</p> <p>This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies.</p>	100% of Amount at Risk	<p><b><u>Measurement Period</u></b> Annual</p> <p><b><u>Reporting Period</u></b> Quarterly</p>
Retail Paper Claims Accuracy	1% of Rx Administration Fee	<p>99% of Retail Paper Claims will be processed without payment errors. This Guarantee will be calculated based on the number of Retail Paper Pharmacy Claims paid or denied correctly divided by the total number of Retail Paper Pharmacy Claims paid. This Guarantee excludes Prescription Drugs dispensed by Specialty Service Pharmacies.</p>	100% of Amount at Risk	<p><b><u>Measurement Period</u></b> Annual</p> <p><b><u>Reporting Period</u></b> Quarterly</p>
On-Site Pharmacy Audits	1% of Rx Administration Fee	<p>A minimum of 3% of retail network pharmacies filling more than 250 Claims during the previous calendar year will receive an on-site audit subject to PBM auditing standards.</p>	100% of Amount at Risk	<p><b><u>Measurement Period</u></b> Annual</p> <p><b><u>Reporting Period</u></b> Quarterly</p>



**INTER-PLAN ARRANGEMENTS SCHEDULE  
TO ADMINISTRATIVE SERVICES AGREEMENT  
WITH  
OWENS & MINOR MEDICAL, INC.**

This Inter-Plan Arrangement Schedule supplements and amends the Administrative Services Agreement and is effective as of June 1, 2017. In the event of an inconsistency between the applicable provisions of this Schedule, any other Schedule and/or the Agreement, the terms of this Schedule shall govern, but only as they relate to the Inter-Plan Arrangements. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

**Out-of-Area Services**

**Overview**

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements". These Inter-Plan Arrangements operate under rules and procedures issued by BCBSA. Whenever Members access healthcare services outside the geographic area Anthem serves (the "Anthem Service Area"), the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the Anthem Service Area, Members obtain care from healthcare Providers that have a contractual agreement ("Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from healthcare Providers in the Host Blue geographic area that do not have a contractual agreement ("Non-Participating Providers") with the Host Blue. Anthem remains responsible for fulfilling its contractual obligations to Employer. Anthem's payment practices in both instances are described below.

This disclosure describes how Claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. Note that dental care, Prescription Drug or vision benefits may not be processed through Inter-Plan Arrangements.

If the Plan covers only limited healthcare services received outside of Anthem's Service Area, services other than those listed as Covered Services (e.g., emergency services) in the Benefits Booklet will not be covered when processed through any Inter-Plan Arrangements, unless authorized by Anthem. Providers providing such non-Covered Services will be considered Non-Participating Providers.

**A. BlueCard<sup>®</sup> Program**

The BlueCard<sup>®</sup> Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services outside the Anthem Service Area, the Host Blue will be responsible for contracting and handling all interactions with its Participating Providers. The financial terms of the BlueCard Program are described generally below.

**1. Liability Calculation Method Per Claim**

**a. Member Liability Calculation**

Unless subject to a fixed dollar copayment, the calculation of the Member liability on Claims for Covered Services will be based on the lower of the Participating Provider's Billed Charges or the negotiated price made available to Anthem by the Host Blue.

**b. Employer Liability Calculation**

The calculation of Employer liability on Claims for Covered Services will be based on the negotiated price made available to Anthem by the Host Blue. Sometimes, this negotiated price may be greater for a given service or services than the Billed Charges in accordance with how the Host Blue has negotiated with its Participating Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the Billed Charges, Employer may be liable for the excess amount even when

the Member's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the Provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the Participating Provider, even when the contracted price is greater than the Billed Charges.

## 2. Claims Pricing

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's Participating Provider contracts. The negotiated price made available to Anthem by the Host Blue may be represented by one of the following:

- (i) An actual price. An actual price is a negotiated rate of payment in effect at the time a Claim is processed without any other increases or decreases; or
- (ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a Claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other Claim- and non-Claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a Claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or
- (iii) An average price. An average price is a percentage of Billed Charges in effect at the time a Claim is processed representing the aggregate payments negotiated by the Host Blue with all of its Participating Providers or a similar classification of its Participating Providers and other Claim- and non-Claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether it will use an actual, estimated or average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price Employer pays on a specific Claim and the actual amount the Host Blue pays to the Participating Provider. However, the BlueCard Program requires that the amount paid be a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims.

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future Claim prices. As a result, the amounts charged to Employer will be adjusted in a following year, as necessary, to account for over- or under-estimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from Employer. Upon termination, Employer will not receive a refund or charge from the variance account.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of Claims processed and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

## B. Negotiated Arrangements

With respect to one or more Host Plans, instead of using the BlueCard Program, Anthem may process Claims for Covered Services through negotiated arrangements. A negotiated arrangement is an agreement negotiated between Anthem and one or more Host Blues for any Employer that is not delivered through the BlueCard Program ("Negotiated Arrangement").

In addition, if Anthem and Employer agree that (a) Host Blue(s) shall make available (a) custom healthcare Provider network(s) in connection with this Agreement, then the terms and conditions set forth in Anthem's Negotiated Arrangement(s) with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of Claims when Members access such network(s). In negotiating such arrangement(s), Anthem is not acting on behalf of or as an agent for Employer, the Plan or Members.

### *Member Liability Calculation*

The calculation of Member cost-sharing will be based on the lower of either Billed Charges or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) that the Host Blue makes available to Anthem and that allows Members access to Participating Providers.

## C. Special Cases: Value-Based Programs

### *Definitions*

1. **Accountable Care Organization (ACO):** A group of Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.
2. **Care Coordination:** Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.
3. **Care Coordinator:** An individual within a Provider organization who facilitates Care Coordination for patients.
4. **Care Coordinator Fee:** A fixed amount paid by a Host Plan to Providers periodically for Care Coordination under a Value-Based Program.
5. **Global Payment/Total Cost of Care:** A payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient, such as outpatient, physician, ancillary, hospital services, and prescription drugs.
6. **Patient-Centered Medical Home (PCMH):** A model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.
7. **Provider Incentive:** An additional amount of compensation paid to a Provider by a Host Blue, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.
8. **Shared Savings:** A payment mechanism in which the Provider and the payer share cost savings achieved against a target cost budget based on agreed upon terms and may include downside risk.
9. **Value-Based Program (VBP):** An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

### *Value-Based Programs Overview*

Members may access Covered Services from Providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

### *Value-Based Programs under the BlueCard Program*

#### Value-Based Programs Administration

Under Value-Based Programs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways: retrospective settlements, Provider Incentives, a share of target savings, Care Coordinator Fees and/or other allowed amounts.

The Host Blue may pass these Provider payments to Anthem, which Anthem will pass directly on to Employer as either an amount included in the price of the Claim or an amount charged separately in addition to the Claim.

When such amounts are included in the price of the Claim, the Claim may be billed using one of the following pricing methods, as determined by the Host Blue:

- (i) **Actual Pricing:** The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the Claim. These charges are passed to Employer via an enhanced Provider fee schedule.
- (ii) **Supplemental Factor:** The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the Claim as an amount based on a specified supplemental factor (e.g., a small percentage increase in the Claim amount). The supplemental factor may be adjusted from time to time.

When such amounts are billed separately from the price of the Claim, they may be billed using a Per Member Per Month billing for Value-Based Programs incentives/Shared Savings settlements to accounts outside of the Claim system. Anthem will pass these Host Blue charges directly through to Employer as a separately identified amount on the Employer billings.

The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard Claim pricing section above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

- Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.
- Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.

The Host Blue will not receive compensation resulting from how estimated, average or PMPM price methods, described above, are calculated. If the Agreement terminates, Employer will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of this Agreement.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of Claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

Note: Members will not bear any portion of the cost of Value-Based Programs except when a Host Blue uses either average pricing or actual pricing to pay Providers under Value-Based Programs.

#### Care Coordinator Fees

Host Blues may also bill Anthem for Care Coordinator Fees for Provider services which Anthem will pass on to Employer as follows:

1. PMPM billings; or
2. Individual Claim billings through applicable care coordination codes from the most current editions of either Current Procedural Terminology (CPT) published by the American Medical Association (AMA) or Healthcare

Common Procedure Coding System (HCPCS) published by the U.S. Centers for Medicare and Medicaid Services (CMS).

Anthem and Employer will not impose Member cost-sharing for Care Coordinator Fees.

#### *Value-Based Programs under Negotiated Arrangements*

If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Members, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted above.

### **D. Non-Participating Providers Outside Anthem's Service Area**

#### **1. Allowed Amounts and Member Liability Calculation**

Unless otherwise described in the Benefits Booklet, when Covered Services are provided outside of Anthem's Service Area by Non-Participating Providers, Anthem may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount the Member pays for such services as deductible, copayment or coinsurance will be based on that allowed amount. Also, the Member may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment Anthem will make for the covered services as set forth in this paragraph.

#### **2. Exceptions**

In certain situations, which may occur at Employer's direction, Anthem may use other pricing methods, such as Billed Charges, the pricing Anthem would use if the healthcare services had been obtained within Anthem's Service Area, or a special negotiated price to determine the amount Anthem will pay for services provided by Non-Participating Providers. In these situations, the Member may be liable for the difference between the amount that the Non-Participating Provider bills and the payment Anthem makes for the Covered Services as set forth in this paragraph.

### **E. Blue Cross Blue Shield Global Core Program**

#### **General Information**

If Members are outside the United States (hereinafter, "BlueCard Service Area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing Covered Services. The Blue Cross Blue Shield Global Core Program is not served by a Host Blue. As such, when Members receive care from Providers outside the BlueCard Service Area, Members will typically have to pay the Providers and submit the Claims themselves to obtain reimbursement for these services.

#### **Inpatient Services**

In most cases, if Members contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their cost-share amounts. In such cases, the hospital will submit Member Claims to the Blue Cross Blue Shield Global Core Service Center to initiate Claims processing. However, if the Member paid in full at the time of service, the Member must submit a Claim to obtain reimbursement for Covered Services.

#### **Outpatient Services**

Physicians, urgent care centers and other outpatient Providers located outside the BlueCard Service Area will typically require Members to pay in full at the time of service. Members must submit a Claim to obtain reimbursement for Covered Services.

## F. Return of Overpayments

Recoveries of overpayments can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits, utilization review refunds and unsolicited refunds. Recoveries will be applied, in general, on either a Claim-by-Claim or prospective basis. If recovery amounts are passed on a Claim-by-Claim basis from a Host Blue to Anthem they will be credited to Employer. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments. The fees of such a third party may be charged to Employer as a percentage of the recovery.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, Anthem will request the Host Blue to provide full refunds from Participating Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original Claim. For Care Coordinator Fees associated with Value-Based Programs, Anthem will request such refunds for a period of only up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of Claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements or (c) would jeopardize the Host Blue's relationship with its Participating Providers, notwithstanding to the contrary any other provision of this Agreement.

## G. Modifications or Changes to Inter-Plan Arrangement Fees or Compensation

Modifications or changes to Inter-Plan Arrangement fees or compensation are generally made effective January 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes resulting in an increase in fees paid by Employer, Anthem shall provide Employer with at least thirty (30) days' advance written notice of any modification or change to such Inter-Plan Arrangements fees or compensation describing the change and the effective date thereof and Employer right to terminate this Agreement without penalty by giving written notice of termination before the effective date of the change. If Employer fails to respond to the notice and does not terminate this Agreement during the notice period, Employer will be deemed to have approved the proposed changes, and Anthem will then allow such modifications to become part of this Agreement.

## H. Fees and Compensation

Employer agrees to reimburse Anthem for certain fees and compensation which Anthem is obligated under the applicable Inter-Plan Arrangements described in this Schedule to pay to the Host Blues, to BCBSA and/or to vendors of BlueCard Program-related services. The specific Inter-Plan Arrangements fees and compensation, including any administrative and/or network access fee that a Host Blue may charge under the BlueCard Program, a Negotiated Arrangement, and BlueCard Worldwide are charged to Employer are set forth in Section 7 of Schedule A to the Agreement. The various Inter-Plan Arrangements Fees and compensation may be revised from time to time as described in section G.

A description of the various Claim processing fees that may be listed on Schedule A is as follows:

**Access Fee:** The Access Fee is charged by the Host Blue to Anthem for making its applicable Provider network available to Members. The Access Fee will not apply to Non-Participating Provider Claims. The Access Fee is charged on a per Claim basis and is charged as a percentage of the discount/differential Anthem receives from the applicable Host Blue subject to a maximum of \$2,000 per Claim.

Instances may occur in which the Claim payment is zero or Anthem pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, Anthem will pay the Host Blue's Access Fee and pass it along directly to Employer as stated above even though Employer paid little or had no Claim liability.

**Administrative Expense Allowance (AEA) Fee:** The AEA Fee is a fixed per Claim dollar amount charged by the Host Blue to Anthem for administrative services the Host Blue provides in processing Claims for Employer's Members. The dollar amount is normally based on the type of Claim (e.g. institutional, professional, international, etc.) and can also be based on the size of group enrollment. When charged, Anthem passes the AEA Fee directly on to Employer.

**Per Subscriber Per Month (PSPM) Fee:** The PSPM Fee is a financial arrangement negotiated between the Host Blue and Employer and replaces all other fees, including the Access Fee and AEA. The PSPM dollar amount is



charged on a per Subscriber per month basis by the Host Blue to Anthem for administrative services the Host Blue provides in processing Claims for Employer's Members. The dollar amount can also be based on the size of group enrollment.

**Non-Standard AEA Fee:** The Non-Standard AEA Fee is a financial arrangement negotiated between the Host Blue and Anthem and replaces all other fees, including the Access Fee and AEA. The Non-Standard AEA is a fixed per Claim dollar amount charged by the Host Blue to Anthem for administrative services the Host Blue provides in processing Claims for Employer's Members.

**Central Financial Agency (CFA) Fee:** The CFA connects Blue Cross and/or Blue Shield Licensee's local bank accounts to an automated clearinghouse (ACH). The CFA Fee is a fixed dollar amount per payment notice and is paid by Anthem to BCBSA outside of the CFA. This fee applies each time Anthem receives an electronic payment notice from the CFA indicating that a Host Blue incurred Claim-related liability on Anthem's behalf and requesting that Anthem either approve or deny payment.

**ITS Transaction Fee:** The ITS delivery platform allows all Blue Cross and/or Blue Shield Licensees to connect with each other through a standardized system to facilitate the operation of Inter-Plan Arrangements. The ITS Transaction Fee applies each time a Claims transaction interchange occurs between Anthem and a Host Blue. When a Host Blue receives a Claim, it applies Provider pricing information, sets forth its discount and related savings and sends this information to Anthem electronically. Anthem then adjudicates the Claim, computes the approved Provider payment amount, calculates the AEA and Access Fee, computes net liability and sends a response electronically to the Host Blue. The Host Blue then pays the Provider and issues an electronic payment notice to Anthem via the CFA. The ITS Transaction Fee is five cents per interchange and is paid to BCBSA. For each Claim, there are a minimum of three interchanges, but there could be more depending on the complexity of the Claim.

Other potential BlueCard Program-related fees include:

**Toll-free (e.g., 800 number) Number Fees:** These fees are charged by BCBSA to Anthem.

- BlueCard Eligibility (800.676.BLUE) – This service provides a centralized number for Providers to reach a Member's Home Licensee to obtain information on membership, coverage and pre-certification. The fees represent charges allocated to the member's Home Licensee based on the percentage of calls by alpha prefix.
- BlueCard Access (800.810.BLUE) – This service provides a centralized number for Members to obtain a list of Participating Providers. The fees represent charges allocated to a Member's Home Licensee based on calls by alpha prefix.

**PPO Provider Directory Fee:** This service provides print-on-demand Provider directories. This fee is charged by BCBSA to Anthem. Anthem passes the PPO Provider Directory Fee directly on to Employer if printed directories are requested. The amount of the fee is dependent upon page length and number ordered; includes shipping, taxes and system maintenance costs.





# MEDICAL BENEFIT BOOKLET

For  
**OWENS & MINOR, INC.**  
Core PPO Plan

Effective Date: January 1, 2020

**Administered By**



**Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.**

**If You need assistance in Spanish to understand this document, You may request it for free by calling Member Services at the number on Your Identification Card.**

Core PPO Plan

This Benefit Booklet provides You with a description of Your benefits while You are enrolled under the health care plan (the Plan) offered by Your Employer. You should read this booklet carefully to familiarize yourself with the Plan's main provisions and keep it handy for reference. A thorough understanding of Your coverage will enable You to use Your benefits wisely. If You have any questions about the benefits as presented in this Benefit Booklet, please contact Your Employer's Group Health Plan Administrator or call the Claims Administrator's Member Services Department.

The Plan provides the benefits described in this Benefit Booklet only for eligible Members. The health care services are subject to the Limitations and Exclusions, Copayments, Deductible, and Coinsurance requirements specified in this Benefit Booklet. Any group plan or certificate which You received previously will be replaced by this Benefit Booklet.

**Your Employer has agreed to be subject to the terms and conditions of Anthem's provider agreements which may include precertification and utilization management requirements, timely filing limits, and other requirements to administer the benefits under this Plan.**

Anthem Blue Cross and Blue Shield, or "Anthem" has been designated by Your Employer to provide administrative services for the Employer's Group Health Plan, such as claims processing, care management, and other services, and to arrange for a network of health care Providers whose services are covered by the Plan.

Important: This is not an insured benefit Plan. The benefits described in this Benefit Booklet or any rider or amendments attached hereto are funded by the Employer who is responsible for their payment. **Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.**

Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, permitting Anthem to use the Blue Cross and Blue Shield Service Marks in portions of the State of Virginia. Although Anthem is the Claims Administrator and is licensed in Virginia, You will have access to Providers participating in the Blue Cross and Blue Shield Association BlueCard® PPO network across the country. Anthem has entered into a contract with the Employer on its own behalf and not as the agent of the Association.

#### **Verification of Benefits**

Verification of benefits is available for Members or authorized healthcare Providers on behalf of Members. You may call Member Services with a benefits inquiry or verification of benefits during normal business hours (8:00 a.m. to 8:00 p.m. eastern time). Please remember that a benefits inquiry or verification of benefits is NOT a verification of coverage of a specific medical procedure. Verification of benefits is NOT a guarantee of payment. **CALL THE MEMBER SERVICES NUMBER ON YOUR IDENTIFICATION CARD or see the section titled Health Care Management for Precertification rules.**

#### **Identity Protection Services**

Identity protection services are available with Your Employer's Anthem health plans. To learn more about these services, please visit [www.anthem.com/resources](http://www.anthem.com/resources).

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## MEMBER RIGHTS AND RESPONSIBILITIES

As a Member You have rights and responsibilities when receiving health care. As Your health care partner, the Claims Administrator wants to make sure Your rights are respected while providing Your health benefits. That means giving You access to the Claims Administrator's network health care Providers and the information You need to make the best decisions for Your health. As a Member, You should also take an active role in Your care.

### You have the right to:

- Speak freely and privately with Your health care Providers about all health care options and treatment needed for Your condition no matter what the cost or whether it is covered under Your Plan.
- Work with your Doctors to make choices about your health care.
- Be treated with respect and dignity.
- Expect the Claims Administrator to keep Your personal health information private by following the Claims Administrator's privacy policies, and state and Federal laws.
- Get the information You need to help make sure You get the most from Your health Plan, and share Your feedback. This includes information on:
  - The Claims Administrator's company and services.
  - The Claims Administrator network of health care Providers.
  - Your rights and responsibilities.
  - The rules of Your health Plan.
  - The way Your health Plan works.
- Make a complaint or file an appeal about:
  - Your health Plan and any care You receive.
  - Any Covered Service or benefit decision that Your health Plan makes.
- Say no to care, for any condition, sickness or disease, without having an effect on any care You may get in the future. This includes asking Your Doctor to tell You how that may affect Your health now and in the future.
- Get the most up-to-date information from a health care Provider about the cause of Your illness, Your treatment and what may result from it. You can ask for help if You do not understand this information.

### You have the responsibility to:

- Read all information about Your health benefits and ask for help if You have questions.
- Follow all health Plan rules and policies.
- Choose a Network Primary Care Physician, also called a PCP, if Your health Plan requires it.
- Treat all Doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call Your health care Provider's office if You may be late or need to cancel.
- Understand Your health problems as well as You can and work with Your health care Providers to make a treatment plan that You all agree on.
- Inform Your health care Providers if You don't understand any type of care you're getting or what they want You to do as part of Your care plan.
- Follow the health care plan that You have agreed on with Your health care Providers.
- Give the Claims Administrator, Your Doctors and other health care Providers the information needed to help You get the best possible care and all the benefits You are eligible for under Your health Plan. This may include information about other health insurance benefits You have along with Your coverage with the Plan.
- Inform Member Services if You have any changes to Your name, address or family members covered under Your Plan.

If You would like more information, have comments, or would like to contact the Claims Administrator, please go to [anthem.com](http://anthem.com) and select Customer Support > Contact Us. Or call the Member Services number on Your Identification Card.

The Claims Administrator wants to provide high quality customer service to our Members. Benefits and coverage for services given under the Plan are governed by the Employer's Plan and not by this Member Rights and Responsibilities statement.

#### **How to Obtain Language Assistance**

Anthem is committed to communicating with our Members about their health plan, regardless of their language. Anthem employs a language line interpretation service for use by all of our Member Services Call Centers. Simply call the Member Services phone number on the back of Your Identification Card and a representative will be able to assist You. Translation of written materials about Your benefits can also be requested by contacting Member Services. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with Your needs.

## SCHEDULE OF BENEFITS

The Maximum Allowed Amount is the amount the Claims Administrator will reimburse for services and supplies which meet its definition of Covered Services, as long as such services and supplies are not excluded under the Member's Plan; are Medically Necessary; and are provided in accordance with the Member's Plan. See the Definitions and Claims Payment sections for more information. Under certain circumstances, if the Claims Administrator pays the healthcare Provider amounts that are Your responsibility, such as Deductibles, Copayments or Coinsurance, the Claims Administrator may collect such amounts directly from You. You agree that the Claims Administrator has the right to collect such amounts from You.

Schedule of Benefits	Network	Out-of-Network
<b>Plan Year Deductible</b>		
• Individual	\$2,500	\$7,500
• Family	\$5,000	\$15,000
Copayments and charges in excess of the Maximum Allowed Amount do not contribute to the Deductible.		
<b>All Covered Services are subject to the Deductible unless otherwise specified in this booklet.</b>		
Amounts satisfied toward the Out-of-Network Plan year Deductible will also be applied toward the Network Plan year Deductible. Amounts satisfied toward the Network Plan year Deductible will <b>NOT</b> be applied toward the Out-of-Network Plan year Deductible.		
<b>Your Plan has an embedded Deductible which means:</b>		
<ul style="list-style-type: none"> <li>• If You, the Subscriber, are the only person covered by this Plan, only the "Individual" amounts apply to You.</li> <li>• If You also cover Dependents (other family members) under this Plan, both the "Individual" and the "Family" amounts apply. The "Family" Deductible amounts can be satisfied by any combination of family members but You could satisfy Your own "Individual" Deductible amount before the "Family" amount is met. You will never have to satisfy more than Your own "Individual" Deductible amount. If You meet Your "Individual" Deductible amount, Your other family member's claims will still accumulate towards their own "Individual" Deductible and the overall "Family" amounts. This continues until Your other family members meet their own "Individual" Deductible or the entire "Family" Deductible is met.</li> </ul>		
<b>Coinsurance After the Plan Year Deductible is Met (Unless Otherwise Specified)</b>		
• Plan Pays	70%	50%
• Member Pays	30%	50%
All payments are based on the Maximum Allowed Amount and any negotiated arrangements. For Out-of-Network Providers, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges. Depending on the service, this difference can be substantial.		

Schedule of Benefits	Network	Out-of-Network
<b>Out-of-Pocket Maximum Per Plan Year</b> Includes Coinsurance, Plan Year Deductible and Copayments.		
• <b>Individual</b>	<b>\$6,550</b>	<b>\$19,650</b>
• <b>Family</b>	<b>\$13,100</b>	<b>\$39,300</b>
Does <u>NOT</u> include charges in excess of the Maximum Allowed Amount, Non-Covered Services, services deemed not Medically Necessary by Medical Management and/or Anthem and penalties for non-compliance.		
Amounts satisfied toward the Out-of-Network Out-of-Pocket Maximum will also be applied toward the Network Out-of-Pocket Maximum. Amounts satisfied toward the Network Out-of-Pocket Maximum will <b>NOT</b> be applied toward the Out-of-Network Out-of-Pocket Maximum.		
<b>Your Plan has an embedded Out-of-Pocket which means:</b>		
<ul style="list-style-type: none"> <li>• If You, the Subscriber, are the only person covered by this Plan, only the "Individual" amounts apply to You.</li> <li>• If You also cover Dependents (other family members) under this Plan, both the "Individual" and "Family" amounts apply. The "Family" Out-of-Pocket amounts can be satisfied by any combination of family members but You could satisfy Your own "Individual" Out-of-Pocket amount before the "Family" amount is met. You will never have to satisfy more than Your own "Individual" Out-of-Pocket amount. If You meet Your "Individual" amount, other family member's claims will still accumulate towards their own "Individual" Out-of-Pocket and the overall "Family" amounts. This continues until Your other family members meet their own "Individual" Out-of-Pocket or the entire "Family" Out-of-Pocket is met.</li> </ul>		

Benefits	Network (You Pay)	Out-of-Network (You Pay)
<b>Note: All dollar and visit limits are combined Network and Out-of-Network, unless otherwise noted. Any benefits with combined visit limits will count services on the same date of service as 1 visit, unless otherwise noted.</b>		
<b>Allergy Care</b>		
<ul style="list-style-type: none"> <li>Allergy Treatment and Testing</li> </ul>	No Deductible/0%	Deductible/50%
<b>Behavioral Health / Substance Abuse Care</b>		
<b>Hospital Inpatient Services Accommodations/Ancillaries</b>		
<ul style="list-style-type: none"> <li>Institutional / Residential Treatment Centers</li> <li>Professional</li> </ul>	Deductible/30% Deductible/30%	Deductible/50% Deductible/50%
<ul style="list-style-type: none"> <li>Includes Detox</li> <li>Includes Eating Disorders</li> <li>Methadone Clinics are covered.</li> <li>Applied Behavioral Analysis (ABA) Therapy is not covered.</li> </ul>		
<b>Outpatient Services</b>		
<ul style="list-style-type: none"> <li>Institutional and Professional Outpatient</li> <li>Professional – Office, including Online Visits</li> </ul>	Deductible/30% \$30 Copayment	Deductible/50% Deductible/50%
<ul style="list-style-type: none"> <li>Includes Intensive Outpatient Therapy (IOP) and Partial Hospitalization (PHP).</li> <li>Eating Disorders are covered.</li> <li>Methadone Clinics are covered.</li> <li>Applied Behavioral Analysis (ABA) Therapy is not covered</li> </ul>		
<b>Coverage for the treatment of Behavioral Health and Substance Abuse Care conditions is provided in compliance with federal law.</b>		
<b>Clinical Trials</b> Please see Clinical Trials under Benefits section for further information.	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received
<b>Dental Accident / Oral Surgery / TMJ Services</b>		
<b>Dental Accident</b>		
<ul style="list-style-type: none"> <li>Treatment of an accidental Injury to sound and natural teeth.</li> <li>Treatment must be completed within 12 months of the accident.</li> </ul>	Covered at the benefit level of the services billed	Covered at the Out-of-Network benefit level of the services billed
<b>TMJ Treatment</b>		
<ul style="list-style-type: none"> <li>Medical treatment (surgical and non-surgical)</li> <li>Appliances</li> </ul>	Not Covered	Not Covered



Benefits	Network (You Pay)	Out-of-Network (You Pay)
<b>Dental Accident / Oral Surgery / TMJ Services continued...</b>		
<b>Oral Surgery</b> <ul style="list-style-type: none"> <li>Excludes removal of impacted teeth</li> <li>Dental Anesthesia is covered if related to a payable oral surgery</li> </ul>	Covered at Surgical level	Covered at Surgical level
<b>Diagnostic Services / Diagnostic X-ray and Lab Tests</b>		
<ul style="list-style-type: none"> <li>Outpatient Institutional/*Professional, Independent Lab and Pre-surgical and Pre-admission Testing</li> <li>*High Diagnostic Imaging (MRI, MRA, CAT, PET and SPECT)</li> <li>Office Setting <ul style="list-style-type: none"> <li>Primary Care Physician</li> <li>Specialty Care Physician</li> </ul> </li> </ul>	No Deductible/30%  Deductible/30%  \$30 Copayment \$60 Copayment	Deductible/50%  Deductible/50%  Deductible/50% Deductible/50%
*Hospital based professional services by non-par providers are covered at the Network benefit level if rendered at a Network Facility.		
<b>Note: Diagnostic services are any claim for services performed to diagnose an illness or Injury.</b>		
<b>Emergency Care, Urgent Care, and Ambulance Services</b>		
<b>Emergency Medical Condition</b> - Emergency Room <ul style="list-style-type: none"> <li>Facility/Professional/Emergency Room Physician (See Note)</li> </ul>	Deductible/30%	Deductible/30%
<b>Non-Emergency Medical Condition</b> - Emergency Room <ul style="list-style-type: none"> <li>Facility / Professional/Emergency Room Physician (See Note)</li> </ul>	Deductible/30%	Deductible/50%
<b>Urgent Care</b> (See Note) <ul style="list-style-type: none"> <li>Outpatient Institutional</li> <li>Outpatient Professional</li> <li>Office Professional <ul style="list-style-type: none"> <li>Primary Care Physician</li> <li>Specialty Care Physician</li> </ul> </li> </ul>	\$60 Copayment No Deductible/0% \$30 Copayment \$60 Copayment	Deductible/50% Deductible/50% Deductible/50% Deductible/50%
<b>Ambulance (Air / Ground)</b> – Medically Necessary	Deductible/30%	Deductible/30%
<b>Note: Care received Out-of-Network for an Emergency Medical Condition will be provided at the Network level of benefits if the following conditions apply:</b> A medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: (1) Placing the health of the individual or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.		

Benefits	Network (You Pay)	Out-of-Network (You Pay)
<b>Eye Care – Medically Necessary</b>		
<ul style="list-style-type: none"> <li>Medical eye care exams (treatment of disease or Injury to the eye) Includes Vision Therapy               <ul style="list-style-type: none"> <li>Outpatient</li> <li>Office                   <ul style="list-style-type: none"> <li>Primary Care Physician</li> <li>Specialty Care Physician</li> </ul> </li> </ul> </li> </ul>	Deductible/30%	Deductible/50%
<ul style="list-style-type: none"> <li>Glasses or contacts following cataract surgery Limited to one occurrence and includes initial frames and lenses, or contact lenses following cataract surgery</li> </ul>	Deductible/30%	Deductible/50%
<b>Vision Hardware</b>	Not Covered	Not Covered
<b>Hearing Care – Medically Necessary</b>		
<ul style="list-style-type: none"> <li>Audiometric exam / Hearing evaluation test.               <ul style="list-style-type: none"> <li>Outpatient</li> <li>Office                   <ul style="list-style-type: none"> <li>Primary Care Physician</li> <li>Specialty Care Physician</li> </ul> </li> </ul> </li> </ul>	Deductible/30%	Deductible/50%
<ul style="list-style-type: none"> <li>Hearing aids and hearing aid accessories are not covered</li> </ul>		
<b>Home Health Care (HHC) Services</b>	Deductible/30%	Deductible/50%
<ul style="list-style-type: none"> <li>Home Health Care is limited to 100 visits per benefit period combined Network and Out-of-Network</li> </ul>		
<b>Home Infusion Therapy</b> is covered and visits do not count toward the HHC visit maximum.	Deductible/30%	Deductible/50%
<b>Private Duty Nursing</b>	Deductible/30%	Deductible/50%
<ul style="list-style-type: none"> <li>Is only covered in the home</li> <li>Visits count toward the HHC visit maximum</li> </ul>		
<b>Hospice Care Services</b>	Deductible/30%	Deductible/50%
<ul style="list-style-type: none"> <li>Respite Care is covered</li> <li>Bereavement Counseling is covered</li> </ul>	Covered at the benefit level of the services billed	Deductible/50%
<b>Hospital Inpatient Services – Pre-certification Required</b>		
<ul style="list-style-type: none"> <li><b>Room and Board (Semiprivate or ICU/CCU) and Hospital Ancillary Services</b></li> </ul>	Deductible/30%	Deductible/50%
<ul style="list-style-type: none"> <li><b>Inpatient Physical Medical Rehab</b> <ul style="list-style-type: none"> <li>Limited to 60 days per Plan Year, combined Network and Out-of-Network</li> </ul> </li> </ul>	Deductible/30%	Deductible/50%

Benefits	Network (You Pay)	Out-of-Network (You Pay)
<b>Inpatient Hospital Services continued...</b>		
<ul style="list-style-type: none"> <li><b>Inpatient Therapies</b> <ul style="list-style-type: none"> <li>Cardiac Rehab / Chemotherapy / Radiation / Dialysis/ Hemodialysis / Infusion / Physical / Occupational / Speech / Respiratory / Vision</li> </ul> </li> <li><b>Physician Services:</b> <ul style="list-style-type: none"> <li>Surgeon</li> <li>Assistant Surgeon</li> <li>Anesthesiologist</li> <li>Radiologist / Pathologist (Diagnostic X-rays / Lab Tests)</li> </ul> </li> </ul> <p>Anesthesiologist, Radiologist / Pathologist (Diagnostic X-rays / Lab Tests) and Assistant Surgeon: Hospital based provider services rendered by non-par providers are covered at the Network benefit level if rendered at a Network Facility.</p>	Deductible/30%	Deductible/50%
<ul style="list-style-type: none"> <li><b>Inpatient Medical Care</b> <ul style="list-style-type: none"> <li>General Medical Care / Intensive Care / Monitoring Consultations / Second Opinions</li> <li>Newborn Care - Includes newborn vision/hearing screening when rendered in an inpatient setting.</li> </ul> </li> </ul> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>For well newborn, no separate deductible is applied. The charge is applied to the mother's claim only.</li> </ul>	Deductible/30%	Deductible/50%
<b>Maternity Care and Other Reproductive Services (Physician)</b>		
<b>Maternity Care</b>	Deductible/30%	Deductible/50%
<ul style="list-style-type: none"> <li>First pre-natal visit applies copayment, then all other pre-natal visits apply at Deductible/Coinsurance</li> <li>Global care (includes pre-and post-natal, delivery)</li> <li>Dependent daughter maternity is covered.</li> <li>Therapeutic and Elective abortion is covered.</li> </ul>		
<b>Infertility Services</b>	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed
<ul style="list-style-type: none"> <li>Covered for services to diagnosis and treat infertility, including Artificial Insemination and Invitro Fertilization, limited to \$20,000 per lifetime, combined Network and Out-of-Network, Medical and Prescription Drugs.</li> <li>Treatment for underlying medical conditions are covered as medical.</li> </ul>		

Benefits	Network (You Pay)	Out-of-Network (You Pay)
<b>Maternity Care and Other Reproductive Services continued...</b>		
<b>Sterilization Services (Precertification required for Inpatient procedures)</b>	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed
<ul style="list-style-type: none"> <li>Sterilization (Vasectomy) is covered.</li> <li>Sterilizations for women will be covered under the "Preventive Care" benefit. Please see that section in Benefits for further details.</li> <li>Reversal of elective sterilization is not covered.</li> </ul>		
<b>Medical Supplies and Equipment</b>		
<b>Durable Medical Equipment (Purchase/Rental)</b>	Deductible/30%	Deductible/50%
<ul style="list-style-type: none"> <li>Byram DME Supplier</li> </ul>	Deductible/0%	Deductible/50%
<b>Medical Supplies</b>	Deductible/30%	Deductible/50%
<b>Diabetic Supplies</b>	Deductible/30%	Deductible/50%
<ul style="list-style-type: none"> <li>Diabetic supplies covered under a Pharmacy Plan are not covered under the Medical Plan, including lancets, syringes, insulin, etc. Diabetic supplies not covered under Pharmacy are covered by the Medical Plan.</li> </ul>		
<b>Prosthetics and Orthotics</b>	Deductible/30%	Deductible/50%
<ul style="list-style-type: none"> <li>Wigs / Toupees are limited to \$1,000 per benefit period, subject to Medical Necessity, combined Network and Out-of-Network.</li> <li>Includes foot orthotics, based on Medical Necessity</li> </ul>		
<b>Nutritional Counseling/Education (Diabetic and Non-Diabetic)</b>		
➤ Outpatient	Deductible/30%	Deductible/50%
➤ Office		
<ul style="list-style-type: none"> <li>Primary Care Physician</li> <li>Specialty Care Physician</li> </ul>	\$30 Copayment \$60 Copayment	Deductible/50% Deductible/50%
<ul style="list-style-type: none"> <li>Limited to 3 visits per benefit period, combined Outpatient and Office and combined Network and Out-of-Network</li> <li>When part of HCR services refer to Preventive Care Benefits.</li> <li>Eating Disorders are covered.</li> </ul>		

Benefits	Network (You Pay)	Out-of-Network (You Pay)
<b>Outpatient Hospital / Facility Services / Ambulatory</b>		
<ul style="list-style-type: none"> <li>Outpatient Hospital Services (Institutional)</li> <li>Ambulatory Surgical Center (Institutional)</li> <li>Clinic (Institutional)</li> <li>Pre-surgical / Pre-admission Testing</li> <li>Outpatient Physician services (surgeon, assistant surgeon, anesthesiologist, radiologist, pathologist, etc.)</li> </ul>	Deductible/30% Deductible/30% Deductible/30% No Deductible/30% Deductible/30%	Deductible/50% Deductible/50% Deductible/50% Deductible/50% Deductible/50%
Anesthesiologist, Radiologist / Pathologist (Diagnostic X-rays / Lab Tests) and Assistant Surgeon: Hospital based provider services rendered by non-par providers are covered at the Network benefit level if rendered at a Network Facility.		
<b>Obesity (Bariatric) Surgery</b>	Not Covered	Not Covered
<b>Physician Services/Visits (Office/Home/Outpatient)</b>		
<b>Visits</b>		
<ul style="list-style-type: none"> <li>Includes Consultations and Second Opinions</li> <li>Office Surgery</li> <li>Includes Family Planning               <ul style="list-style-type: none"> <li>Outpatient</li> <li>Office / Home                   <ul style="list-style-type: none"> <li>Primary Care Physician</li> <li>Specialty Care Physician</li> </ul> </li> </ul> </li> </ul>	Deductible/30% \$30 Copayment \$60 Copayment	Deductible/50% Deductible/50% Deductible/50%
<b>Important Note on Office Visits at an Outpatient Facility:</b> If you have an office visit with your Primary Care Physician or Specialty Care Physician at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under the "Outpatient Facility" section earlier in this Schedule. Please refer to that section for details on the cost shares (e.g., Deductibles, Copayments, Coinsurance) that will apply.		
<b>Online Visit</b> <ul style="list-style-type: none"> <li>Includes Live Health Online providers only. All other online providers are not covered. (For Behavioral Health and Substance Abuse, see that section for benefit details)</li> </ul>	\$15 Copayment	Not Covered
<b>Immunizations (Non-routine) and Injections including Administration</b>		
When part of HCR refer to Preventive Care Benefit Travel Immunizations are not covered.		
<ul style="list-style-type: none"> <li>Outpatient</li> <li>Office</li> </ul>	Deductible/30% No Deductible/0%	Deductible/50% Deductible/50%

Benefits	Network (You Pay)	Out-of-Network (You Pay)
<b>Blood Processing and Storage</b>	Deductible/30%	Deductible/50%
<b>ADD/ADHD</b> <ul style="list-style-type: none"> <li>Includes Autistic Disease, Intellectual Disability, Developmental Delays and Learning Disabilities</li> </ul>	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed
<b>Preventive Services (unless otherwise stated below)</b> <ul style="list-style-type: none"> <li>Prostate Cancer Screenings (PSA)</li> <li>Pap Smear</li> <li>Mammography</li> <li>Colon Cancer Screenings (See Note)</li> </ul>	No Deductible/0% No Deductible/0% No Deductible/0% No Deductible/0%	Not Covered Deductible/50% Deductible/50% Deductible/50% Deductible/50%
Note: Includes routine fecal occult blood test, routine barium edema, routine Sigmoidoscopy/Colonoscopy. Facility and anesthesia billed for routine Sigmoidoscopy/Colonoscopy are covered at the same level as the routine Sigmoidoscopy/Colonoscopy. All services related to routine Sigmoidoscopy/Colonoscopy are covered at the same level as the routine Sigmoidoscopy/Colonoscopy.		
<b>Retail Health Clinic</b>	\$30 Copayment	Deductible/50%
<b>Skilled Nursing Facility</b> <ul style="list-style-type: none"> <li>Limited to 60 days per Plan Year, combined Network and Out-of-Network</li> </ul>	Deductible/30%	Deductible/50%
<b>Therapy Services (Outpatient/Office) (Institutional and Professional)</b>		
<b>Biofeedback Therapy</b> <b>Dialysis/ Hemodialysis</b>	Not Covered Deductible/30%	Not Covered Deductible/50%
<b>Acupuncture Therapy</b> <ul style="list-style-type: none"> <li>Outpatient (Institutional and Professional)</li> <li>Office Professional</li> </ul> Limited to 26 visits per benefit period, combined Institutional and Professional, combined Network and Out-of-Network. Limit does not combine with any other therapy limit.	Deductible/30% \$60 Copayment	Deductible/50% Deductible/50%
<b>Cardiac Rehab</b> <ul style="list-style-type: none"> <li>Outpatient:               <ul style="list-style-type: none"> <li>Institutional</li> <li>Professional</li> </ul> </li> <li>Office Professional</li> </ul> Limited to 36 visits per benefit period, combined Institutional and Professional, combined Network and Out-of-Network. Limit does not combine with any other therapy limit.	\$60 Copayment No Deductible/0% \$60 Copayment	Deductible/50% Deductible/50% Deductible/50%
<b>Chemotherapy / Infusion Therapy / Radiation Therapy</b> <ul style="list-style-type: none"> <li>Outpatient (Institutional and Professional)</li> <li>Office Professional:</li> </ul>	Deductible/30%	Deductible/50%

Benefits	Network (You Pay)	Out-of-Network (You Pay)
<ul style="list-style-type: none"> <li>○ Primary Care Physician</li> <li>○ Specialty Care Physician</li> </ul>	\$30 Copayment \$60 Copayment	Deductible/50% Deductible/50%
<p><b>Therapy Services continued...</b></p> <p><b>Occupational Therapy / Physical Therapy / Speech Therapy / Respiratory Therapy / Cognitive Therapy</b></p> <ul style="list-style-type: none"> <li>• Outpatient:               <ul style="list-style-type: none"> <li>○ Institutional \$60 Copayment Deductible/50%</li> <li>○ Professional No Deductible/0% Deductible/50%</li> </ul> </li> <li>• Office Professional:               <ul style="list-style-type: none"> <li>○ Primary Care Physician \$30 Copayment Deductible/50%</li> <li>○ Specialty Care Physician \$60 Copayment Deductible/50%</li> </ul> </li> </ul> <p>Limited to 90 visits per Plan Year, combined Institutional and Professional, combined Network and Out-of-Network. Visit limit is combined with Occupational Therapy, Physical Therapy, Speech Therapy, Respiratory Therapy and Cognitive Therapy. However, this therapy limit does not combine with any other plan therapy limit.</p> <p><b>Manipulation Therapy</b></p> <ul style="list-style-type: none"> <li>• Primary Care Physician \$30 Copayment Deductible/50%</li> <li>• Specialty Care Physician \$60 Copayment Deductible/50%</li> </ul> <p>Limited to 30 visits per Plan Year, includes manipulations only regardless of provider specialty combined Network and Out-of-Network. Limit does not combine with any other therapy limit.</p> <p><b>Note:</b> Inpatient therapy services will be paid under the Inpatient Hospital benefit.</p>		

Transplants	(You Pay)
<p>Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by the Claims Administrator including necessary acquisition procedures, collection and storage, including Medically Necessary preparatory myeloablative therapy.</p> <p><b>The Center of Excellence requirements do not apply to</b> Cornea and kidney transplants; and any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period.</p> <p><b>Note:</b> Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact the Claims Administrator to determine which Hospitals are Network Transplant Providers. (When calling Member Services, ask to be connected with the Transplant Case Manager for further information.)</p>	
<p><b>Transplant Benefit Period</b></p> <p><b>Center of Excellence/Network Transplant Provider</b> Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Center of Excellence Network Transplant Provider agreement. Contact the Member Services number on Your Identification Card and ask for the Transplant Case Manager for specific Network Transplant Provider information.)</p>	
<p><b>Out-of-Network Transplant Provider</b> Starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.</p>	
<p><b>Live Donor Health Services</b></p> <ul style="list-style-type: none"> <li>• <b>BDCT Facility</b></li> <li>• <b>Network</b></li> <li>• <b>Out-of-Network</b></li> </ul>	<p>No Deductible/0%</p> <p>Deductible/30%</p> <p>Deductible/50%</p>
<p>Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for the procurement of an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.</p>	
<p><b>Bone Marrow Donor Search</b> Limited to \$30,000 per transplant, combined BDCT, Network and Out-of-Network</p> <ul style="list-style-type: none"> <li>• <b>BDCT Facility</b></li> <li>• <b>Network</b></li> <li>• <b>Out-of-Network</b></li> </ul>	<p>No Deductible/0%</p> <p>Deductible/30%</p> <p>Deductible/50%</p>
<p><b>Organ Transplants</b> Donor expenses are covered. Artificial hearts are covered.</p> <p><b>Institutional and Professional:</b></p> <ul style="list-style-type: none"> <li>• <b>BDCT Facility</b></li> <li>• <b>Network</b></li> <li>• <b>Out-of-Network</b></li> </ul>	<p>No Deductible/0%</p> <p>Deductible/30%</p> <p>Deductible/50%</p>



Transplants	(You Pay)
<b>Travel and Lodging</b> <ul style="list-style-type: none"> <li>• <b>BDCT Facility</b></li> <li>• <b>Network</b></li> <li>• <b>Out-of-Network</b></li> </ul> <p>Provided the patient lives at least 75 miles from the covered transplant facility, lodging allowance is \$50 per day for double occupancy and travel and lodging is limited to \$10,000 per transplant, combined BDCT, Network and Out-of-Network.</p>	

Benefits	Network	Out-of-Network
<b>Prescription Drugs</b>		
<b>Prescription Drug Out-of-Pocket Limit Retail and Mail Order</b>		
• Per Member	\$6,550	Not Covered
• Per Family	\$13,100	Not Covered
<p><b>Note:</b> The Network Out-of-Pocket amount combines with the Medical Plan's Network Out-of-Pocket Limit for Covered Services in this Plan. It includes all Copayments You pay for Prescription Drugs from a Retail or Home Delivery (Mail Order) Pharmacy during a Benefit Period.</p> <p>Once the Network Out-of-Pocket Limit is satisfied, You will not have to pay any additional Copayments for Prescription Drugs from a Retail or Home Delivery (Mail Order) Pharmacy for the rest of the Benefit Period.</p>		
<b>Retail Pharmacy Copayment (31-day supply)</b>		
• Tier 1 – Copayment per Prescription	\$15	Not Covered
• Tier 2 – Copayment per Prescription	\$60	Not Covered
• Tier 3 – Copayment per Prescription	\$75	Not Covered
• Tier 4 – Specialty Drugs	50% with \$125 maximum	Not Covered
<p><b>Note:</b> A 90-day supply is available at Maintenance Pharmacies. When You get a 90-day supply at a Maintenance Pharmacy, three (3) Retail Pharmacy Copayments (one for each 30-day period) will apply (excluding Retail Pharmacies). When You get a 30-day supply, one Copayment per Prescription Order will apply.</p>		
<b>Home Delivery (Mail Service) Prescription Drugs Copayment (90-day supply)</b>		
• Tier 1 – Copayment per Prescription	\$38	Not Covered
• Tier 2 – Copayment per Prescription	\$125	Not Covered
• Tier 3 – Copayment per Prescription	\$188	Not Covered
• Tier 4 – Specialty Drugs (30 day supply limit)	50% with \$125 maximum	Not Covered
<p><b>Note:</b> The available day supply may be less than the 31 or 90 days shown above due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.</p>		
<p><b>Note:</b> Covered Preventive Prescription Drugs including immunizations are covered in full.</p>		

Benefits	Network	Out-of-Network
<b>Prescription Drugs</b>		
<p><b>Note:</b> If You request a Tier 2 or Tire 3 Drug when a Tier 1 Drug is available, You will be required to pay the difference in cost between the Tier 2 or Tire 3 Drug and the Tier 1 Drug, in addition to the Tier 1 Copayment. If, however, the prescriber writes "Dispense as Written" or "Do not Substitute," or if there is no Tier 1 Drug available, You will only have to pay the Tier 2 or Tier 3 Copayment as applicable.</p>		
<p><b>Note:</b> A limited number of Prescription Drugs require Prior Authorization for Medical Necessity. If Prior Authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a drug requires Prior Authorization, please call Member Services. If an Out-of-Network Pharmacy is used, the Member must file a claim for reimbursement; the Member may be responsible for the difference between the negotiated rate and the Pharmacy's actual charge.</p>		
<p><b>Note:</b> Certain asthmatic supplies are covered subject to applicable Prescription Drug Copayments when obtained from a Network Pharmacy. Diabetic supplies are covered in full when obtained from a Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if obtained from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment.</p>		

## TOTAL HEALTH AND WELLNESS SOLUTION

### Quick Care Options

Quick Care Options helps to raise Your awareness about appropriate alternatives to Hospital emergency rooms (ERs). When You need care right away, Retail Health Clinics and Urgent Care centers can offer appropriate care for less cost and leave the ER available for actual emergencies. Quick Care Options educates You on the availability of ER alternatives for non-urgent diagnoses and provides the Provider finder website to support searches for ER alternatives.

### ComplexCare

The ComplexCare program reaches out to You if You are at risk for frequent and high levels of medical care in order to offer support and assistance in managing Your health care needs. ComplexCare empowers You for self-care of Your condition(s), while encouraging positive health behavior changes through ongoing interventions. ComplexCare nurses will work with You and Your Physician to offer:

- Personalized attention, goal planning, health and lifestyle coaching.
- Strategies to promote self-management skills and medication adherence.
- Resources to answer health-related questions for specific treatments.
- Access to other essential health care management programs.
- Coordination of care between multiple Providers and services.

The program helps You effectively manage Your health to achieve improved health status and quality of life, as well as decreased use of acute medical services.

### ConditionCare Programs

ConditionCare programs help maximize Your health status, improve health outcomes and control health care expenses associated with the following prevalent conditions:

- Asthma (pediatric and adult).
- Diabetes (pediatric and adult).
- Heart failure (HF).
- Coronary artery disease (CAD).
- Chronic obstructive pulmonary disease (COPD).

#### You will receive:

- 24/7 phone access to a nurse coach who can answer Your questions and give You up-to-date information about Your condition.
- A health review and follow-up calls if You need them.
- Tips on prevention and lifestyle choices to help You improve Your quality of life.

### Future Moms

The Future Moms program offers a guided course of care and treatment, leading to overall healthier outcomes for mothers and their newborns. Future Moms helps routine to high-risk expectant mothers focus on early prenatal interventions, risk assessments and education. The program includes special

management emphasis for expectant mothers at highest risk for premature birth or other serious maternal issues. The program consists of nurse coaches supported by pharmacists, registered dietitians, social workers and medical directors. You will receive:

- 24/7 phone access to a nurse coach who can talk with You about Your pregnancy and answer Your questions.
- *Your Pregnancy Week by Week*, a book to show You what changes You can expect for You and Your baby over the next nine months.
- Useful tools to help You, Your Physician and Your Future Moms nurse coach track Your pregnancy and spot possible risks.

### **24/7 NurseLine**

You may have emergencies or questions for nurses around-the-clock. 24/7 NurseLine provides You with accurate health information any time of the day or night. Through one-on-one counseling with experienced nurses available 24 hours a day via a convenient toll-free number, You can make more informed decisions about the most appropriate and cost-effective use of health care services. A staff of experienced nurses is trained to address common health care concerns such as medical triage, education, access to health care, diet, social/family dynamics and mental health issues. Specifically, the 24/7 NurseLine features:

- A skilled clinical team – RN license (BSN preferred) that helps Members assess systems, understand medical conditions, ensure Members receive the right care in the right setting and refer You to programs and tools appropriate to Your condition.
- Bilingual RNs, language line and hearing impaired services.
- Access to the AudioHealth Library, containing hundreds of audiotapes on a wide variety of health topics.
- Proactive callbacks within 24 to 48 hours for Members referred to 911 emergency services, poison control and pediatric Members with needs identified as either emergent or urgent.
- Referrals to relevant community resources.

### **Standard [Autism Spectrum Disorders (ASD) Program**

The ASD Program is comprised of a specialized, dedicated team of clinicians within Anthem who have been trained on the unique challenges and needs of families with a Member who has a diagnosis of ASD. Anthem provides specialized case management services for Members with autism spectrum disorders and their families. The Program also includes precertification and Medical Necessity reviews for Applied Behavior Analysis, a treatment modality targeting the symptoms of autism spectrum disorders. For families touched by ASD, Anthem's Autism Spectrum Disorders Program provides support for the entire family, giving assistance wherever possible and making it easier for them to understand and utilize care, resulting in access to better outcomes and more effective use of benefits. The ASD Program has three main components:

#### **Education**

- Educates and engages the family on available community resources, helping to create a system of care around the Member.
- Increases knowledge of the disorder, resources, and appropriate usage of benefits

#### **Guidance**

- Applied Behavior Analysis management, including clinical reviews by experienced licensed clinicians. Precertification delivers value, ensuring that the Member receives the right care, from the right Provider, at the right intensity.

- Increased follow-up care encouraged by appointment setting, reminders, attendance confirmation, proactive discharge planning, and referrals.
- Assure that parents and siblings have the best support to manage their own needs.

#### **Coordination**

- Enhanced Member experience and coordination of care.
- Assistance in exploration of medical services that may help the Member, including referrals to medical case management.
- Licensed Behavior Analysts and Program Managers provide support and act as a resource to the interdisciplinary team, helping them navigate and address the unique challenges facing families with an autistic child.

#### **MyHealth Advantage**

MyHealth Advantage is a free service that helps keep You and Your bank account healthier. Here's how it works: the Claims Administrator will review Your incoming health claims to see if the Plan can save You any money. The Claims Administrator can check to see what medications You are taking and alert Your Physician if the Claims Administrator spot a potential drug interaction. The Claims Administrator also keeps track of Your routine tests and checkups, reminding You to make these appointments by mailing You MyHealth Notes. MyHealth Notes summarize Your recent claims. From time to time, The Claims Administrator will offer tips to save You money on Prescription Drugs and other health care supplies.

#### **Virtual Second Opinion**

Facing a medical decision? The Virtual Second Opinion program allows You access to highly specialized Physicians who can provide educational guidance for certain diagnoses, procedures, or courses of treatment. Our advanced analytics engine helps to identify You and other Members to offer support through our nurses and will refer to an independent company that will handle Your second opinion.

With the Virtual Second Opinion program You can:

Learn more about Your condition.

Make sure Your diagnosis is correct.

Better understand and compare Your treatment options.

Find a high quality doctor.

Gain confidence in the treatment You choose.

## **ELIGIBILITY**

**Members who do not enroll within 31 days of being eligible are considered Late Enrollees. Please refer to the “Late Enrollees” provision in this section.**

### **Coverage for the Teammate**

This Benefit Booklet describes the benefits a Teammate may receive under this health care Plan. The Teammate is also called a Subscriber.

### **Coverage for the Teammate’s Dependents**

If the Teammate is covered by this Plan, the Teammate may enroll his or her eligible Dependents. Covered Dependents are also called Members.

### **Eligible Dependents Include:**

- The Teammate’s Spouse. For information on spousal eligibility please contact the Employer.
- The Teammate’s dependent children until the end of the month they attain age 26, legally adopted children from the date the Teammate assumes legal responsibility, foster children that live with the Teammate and for whom the Teammate is the primary source of financial support, children for whom the Teammate assumes legal guardianship and stepchildren. Also included are the Teammate’s children (or children of the Teammate’s Spouse) for whom the Teammate has legal responsibility resulting from a valid court decree.
- Children who are mentally or physically impaired and totally dependent on the Teammate for support, past the age of 26 or older. To be eligible for continued coverage past the age of 26, certification of the impairment is required within 31 days of attainment of age 26. A certification form is available from the Employer or from the Claims Administrator and may be required periodically. You must notify the Claims Administrator and/or the Employer if the Dependent’s marital or tax exemption status changes and they are no longer eligible for continued coverage.

### **Initial Enrollees**

Initial Enrollees and eligible Dependents who were previously enrolled under group coverage which this Plan replaces are eligible for coverage on the Effective Date of this coverage. Coverage will be effective based on the waiting period chosen by the Employer, and will not exceed 90 days.

### **New Hires**

Applications for enrollment must be submitted within 31 days from the date a Teammate is eligible to enroll as set by the Employer. Applications for membership may be obtained from the Employer. Coverage will be effective based on the waiting period chosen by the Employer and will not exceed 90 days. If the Teammate or the Teammate’s Dependents do not enroll when first eligible, the Teammate or the Teammate’s Dependents will be treated as Late Enrollees. Please refer to the “Late Enrollees” provision listed below.

### **Late Enrollees**

If the Teammate or the Teammate’s Dependents do not enroll when first eligible, it will be necessary to wait for the next open enrollment period. However, the Teammate or the Teammate’s Dependents may be eligible for special enrollment as set out below.

### **Special Enrollment Periods**

If a Teammate or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Teammate or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact;
- exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan;
- lost Employer contributions towards the cost of the other coverage; or
- are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

#### **Important Notes About Special Enrollment:**

- Individuals enrolled during Special Enrollment periods are **not** Late Enrollees.
- Individuals or Dependents must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

#### **Medicaid and CHIP Special Enrollment/Special Enrollees**

Eligible Teammates and Dependents may also enroll under two additional circumstances:

- the Teammate's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Teammate or Dependent becomes eligible for a subsidy (state premium assistance program)

The Teammate or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

#### **When Coverage Begins**

If the Teammate applies for coverage when first eligible, coverage will be effective on the date the Employer's length-of-service requirement has been met. The Effective Date of coverage is subject to any length-of-service provision the Employer requires and will not exceed 90 days.

#### **Changing Coverage**

There may be an annual re-enrollment period during which time Members may elect to change their options.

#### **Types of Coverage**

The types of coverage available to the Teammate are indicated at the time of enrollment through the Employer.

#### **Changing Coverage (Adding a Dependent)**

You may add new Dependents to Your Plan by contacting Your Plan Administrator. The Plan Administrator must notify the Claims Administrator. The Plan Administrator is the person named by the Employer to manage the Plan and answer questions about Plan details.

Coverage is provided only for those Dependents the Teammate has reported to the Plan Administrator and added to his or her coverage by completing the correct application.

#### **Marriage and Stepchildren**

A Teammate may add a Spouse and eligible stepchildren within 31 days of the date of marriage by submitting a change-of-coverage form. The Effective Date will be the date of marriage.

If a Teammate does not apply for coverage to add a Spouse and stepchildren within 31 days of the date of marriage, the Spouse and stepchildren are considered Late Enrollees. Please refer to the "Late Enrollees" provision in this section.



## Newborn and Adopted Children

You must contact Your Employer within 31 days to add a newborn or adopted child.

## Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

## OBRA 1993 and Qualified Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) provides specific rules for the coverage of adopted children and children subject to a Qualified Medical Child Support Order (QMCSO).

An eligible Dependent child includes:

- an adopted child, regardless of whether or not the adoption has become final. An “adopted child” is any person under the age of 18 as of the date of adoption or placement for adoption. “Placement for adoption” means the assumption and retention by the Teammate of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.
- a child for whom a Teammate has received a MCSO (a “Medical Child Support Order”) which has been determined by the Employer or Plan Administrator to be a Qualified Medical Child Support Order (“QMCSO”). Upon receipt of a QMCSO, the Employer or Plan Administrator will inform the Teammate and each affected child of its receipt of the order and will explain the procedures for determining if the order is a QMCSO. The Employer will subsequently notify the Teammate and the child(ren) of the determination.

A QMCSO cannot require the Employer to provide any type or form of benefit that it is not already offering.

## Family and Medical Leave

If a covered Teammate ceases active employment due to an Employer-approved medical leave of absence, in accordance with the Family and Medical Leave Act of 1993 (FMLA), coverage will be continued for up to 12 weeks under the same terms and conditions which would have applied had the Teammate continued in active employment. The Teammate must pay his or her contribution share toward the cost of coverage, if any contribution is required.

## Changing Coverage or Removing a Dependent

When any of the following events occur, notify the Employer and ask for appropriate forms to complete:

- divorce;
- death of an enrolled family Member (a different type of coverage may be necessary);
- Dependent child reaches age 26 (see **When Coverage Terminates**); or
- Enrolled Dependent child becomes totally or permanently disabled.

## Teammate Not Actively at Work

Generally, if a Teammate is not actively at work on the date his or her coverage is to be effective, the Effective Date will be postponed until the date the Teammate returns to active status. If a Teammate is not actively at work due to health status, this provision will not apply. A Teammate is also a person still employed by the Employer but not currently active due to health status.

## HOW YOUR PLAN WORKS

**Note: Capitalized terms such as Covered Services, Medical Necessity, and Out-of-Pocket Maximum are defined in the “Definitions” Section.**

### Introduction

Your health Plan is a Preferred Provider Organization (PPO) which is a comprehensive Plan. The Plan is divided into two sets of benefits: Network and Out-of-Network. If You choose a Network Provider, You will receive Network benefits. Utilizing this method means You will not have to pay as much money; Your Out-of-Pocket expenses will be higher when You use Out-of-Network Providers.

Providers are compensated using a variety of payment arrangements, including fee for service, per die m, discounted fees, and global reimbursement.

All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied.

### Network Services

When You use a Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. The Plan has the final authority to decide the Medical Necessity of the service.

**Network Providers** include Primary Care Physicians/Providers (PCPs), Specialists (Specialty Care Physicians/Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with us to care for You. Referrals are never needed to visit a Network Specialist, including behavioral health Providers.

To see a Doctor, call their office:

- Tell them You are an Anthem Member,
- Have Your Member Identification Card handy. The Doctor’s office may ask You for Your group or Member ID number.
- Tell them the reason for Your visit.

When You go to the office, be sure to bring Your Member Identification Card with You.

For services from Network Providers:

1. You will not need to file claims. Network Providers will file claims for Covered Services for You. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by Your Network Provider(s) for any Non-Covered Services You get or when You have not followed the terms of this Benefit Booklet.
2. Precertification will be done by the Network Provider. (See the **Health Care Management – Precertification** section for further details.)

Please read the **Claims Payment** section for additional information on Authorized Services.

### After Hours Care

If You need care after normal business hours, Your doctor may have several options for You. You should call Your doctor’s office for instructions if You need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If You have an Emergency, call 911 or go to the nearest Emergency Room.

## Out-of-Network Services

When You do not use a Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Benefit Booklet.

For services from an Out-of-Network Provider:

- the Out-of-Network Provider can charge You the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments;
- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
- You will have to pay for services that are not Medically Necessary;
- You will have to pay for Non-Covered Services;
- You may have to file claims; and
- You must make sure any necessary Precertification is done. (Please see **Health Care Management – Precertification** for more details.)

## How to Find a Provider in the Network

There are three ways You can find out if a Provider or facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of Network Providers at [www.anthem.com](http://www.anthem.com), which lists the Doctors, Providers, and facilities that participate in this Plan's Network.
- Call Member Services to ask for a list of doctors and Providers that participate in this Plan's Network, based on specialty and geographic area.
- Check with Your doctor or Provider.

If You need details about a Provider's license or training, or help choosing a doctor who is right for You, call the Member Services number on the back of Your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with Your needs.

## The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, Anthem participates in a program called "BlueCard," which provides services to You when You are outside our Service Area. For more details on this program, please see "Inter-Plan Arrangements" in the **Claims Payment** section.

## Copayment

Certain Network services may be subject to a Copayment amount which is a flat-dollar amount You will be charged at the time services are rendered.

Copayments are the responsibility of the Member. Any Copayment amounts required are shown in the **Schedule of Benefits**. Unless otherwise indicated, services which are not specifically identified in this Benefit Booklet as being subject to a Copayment are subject to the **Plan Year Deductible** and payable at the **percentage payable** in the **Schedule of Benefits**.

## Plan Year Deductible

Before the Plan begins to pay benefits (except certain benefits which are subject to Copayment instead of Deductible), You must meet any Deductible required. You must satisfy one Deductible for each type of coverage as explained in the **Schedule of Benefits**. Deductible requirements are stated in the **Schedule of Benefits**.

## HEALTH CARE MANAGEMENT - PRECERTIFICATION

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigative as those terms are defined in this Benefit Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed. A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to You in a lower level of care or lower cost setting/place of care, will not be Medically Necessary if they are given in a higher level of care or higher cost setting/place of care.

Certain Services must be reviewed to determine Medical Necessity in order for You to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. The Plan may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate.

If You have any questions regarding the information contained in this section, You may call the Member Services telephone number on Your Identification Card or visit [www.anthem.com](http://www.anthem.com).

**Coverage for or payment of the service or treatment reviewed is not guaranteed even if the Plan decides Your services are Medically Necessary. For benefits to be covered, on the date You get service:**

1. You must be eligible for benefits;
2. Fees must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under Your Plan;
4. The service cannot be subject to an Exclusion under Your Plan; and
5. You must not have exceeded any applicable limits under Your Plan.

### Types of Reviews:

- **Pre-service Review** – A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.
- **Precertification** – A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for You to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative as those terms are defined in this Benefit Booklet.

For admissions following Emergency Care, You, Your authorized representative or Doctor must tell the Claims Administrator no later than 2 business days after admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

- **Continued Stay/Concurrent Review** - A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

Both Pre-Service and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Doctor with knowledge of Your medical condition, without such care or treatment, Your life or health or Your ability to regain maximum function could be seriously threatened or You could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which the Claims Administrator has a related clinical coverage guideline and are typically initiated by the Claims Administrator.

#### **Failure to Obtain Precertification Penalty:**

**IMPORTANT NOTE: IF YOU OR YOUR NON NETWORK PROVIDER DO NOT OBTAIN THE REQUIRED PRECERTIFICATION, A \$250 PENALTY WILL APPLY AND YOUR OUT-OF-POCKET COSTS WILL INCREASE. THIS DOES NOT APPLY TO MEDICALLY NECESSARY SERVICES FROM A NETWORK OR BLUECARD PROVIDER.**

**The following list is not all inclusive and is subject to change; please call the Member Services telephone number on Your Identification Card to confirm the most current list and requirements for Your Plan.**

#### **Inpatient Admissions**

- Emergency Admissions (Requires Plan notification no later than 2 business days after admission)
- Inclusive of all Acute Inpatient, Skilled Nursing Facility, Long Term Acute Rehab, and OB delivery stays beyond the Federal Mandate minimum length of stay (including newborn stays beyond the mother's stay)

#### **Outpatient Admissions**

- Ablative Techniques as a Treatment for Barrett's Esophagus
- Ambulance Services: Air and Water (excludes 911 initiated emergency Transport)
- Balloon and Self-Expanding Absorptive Sinus Ostial Dilation
- Bone-Anchored and Bone Conduction Hearing Aids
- Breast Procedures; including Reconstructive Surgery, Implants and Other Breast Procedures
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement
- Cervical Total Disc Arthroplasty
- Cochlear Implants and Auditory Brainstem Implants
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System
- Cryoablation for Plantar Fasciitis and Plantar Fibroma
- Cryopreservation of Oocytes or Ovarian Tissue
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain, Cortical, and Cerebellar Stimulation
- Diagnostic Testing
  - ▶ Gene Expression Profiling for Managing Breast Cancer Treatment
  - ▶ Genetic Testing for Cancer Susceptibility
- DME/Prosthetics

- ▶ Augmentative and Alternative Communication (AAC) Devices/Speech Generating Devices (SGD)
- ▶ Electrical Bone Growth Stimulation
- ▶ External (Portable) Continuous Insulin Infusion Pump
- ▶ Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
- ▶ Microprocessor Controlled Lower Limb Prosthesis
- ▶ Oscillatory Devices for Airway Clearance including High Frequency Chest Compression and Intrapulmonary Percussive Ventilation (IPV)
- ▶ Pneumatic Compression Devices for Lymphedema
- ▶ Prosthetics: Electronic or externally powered and select other prosthetics
- ▶ Standing Frame
- ▶ Wheeled Mobility Devices: Manual Wheelchairs-Ultra Lightweight
- ▶ Wheeled Mobility Devices: Wheelchairs-Powered, With or Without Power Seating Systems and Power Operated Vehicles (POVs)
- Electrothermal Shrinkage of Joint Capsules, Ligaments, and Tendons
- Extracorporeal Shock Wave Therapy for Orthopedic Conditions
- Extraosseous Subtalar Joint Implantation and Subtalar Arthroereisis
- Functional Endoscopic Sinus Surgery
- Gastric Electrical Stimulation
- Gender Reassignment Surgery
- GU Conditions
- Hyperbaric Oxygen Therapy (Systemic/Topical)
- Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry
- Implantable Infusion Pumps
- Implantable Middle Ear Hearing Aids
- Implantable or Wearable Cardioverter-Defibrillator
- Implanted Devices for Spinal Stenosis
- Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies
- Lumbar Spinal Fusion and Lumbar Total Disc Arthroplasty
- Lung Volume Reduction Surgery
- Lysis of Epidural Adhesions
- Mandibular/Maxillary (Orthognathic) Surgery
- Manipulation Under Anesthesia of the Spine and Joints other than the Knee
- Maze Procedure
- MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications
- Occipital Nerve Stimulation
- Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Partial Left Ventriculectomy
- Penile Prosthesis Implantation
- Percutaneous Neurolysis for Chronic Neck and Back Pain
- Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty

- Photocoagulation of Macular Drusen
- Plastic/Reconstructive Surgeries:
  - ▶ Abdominoplasty, Panniculectomy, Diastasis Recti Repair
  - ▶ Blepharoplasty
  - ▶ Brachioplasty
  - ▶ Buttock/Thigh Lift
  - ▶ Chin Implant, Mentoplasty, Osteoplasty Mandible
  - ▶ Insertion/Injection of Prosthetic Material Collagen Implants
  - ▶ Liposuction/Lipectomy
  - ▶ Procedures Performed on Male or Female Genitalia
  - ▶ Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
  - ▶ Procedures Performed on the Trunk and Groin
  - ▶ Repair of Pectus Excavatum / Carinatum
  - ▶ Rhinoplasty
  - ▶ Skin-Related Procedures
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Private Duty Nursing
- Radiation Therapy
  - ▶ Intensity Modulated Radiation Therapy (IMRT)
  - ▶ Proton Beam Therapy
  - ▶ Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Radiofrequency Ablation to Treat Tumors Outside the Liver
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion
- Septoplasty
- Suprachoroidal Injection of a Pharmacologic Agent
- Surgical and Ablative Treatments for Chronic Headaches
- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other
- Surgical Treatment of Obstructive Sleep Apnea and Snoring
- Tonsillectomy for Children with or without Adenoidectomy
- Total Ankle Replacement
- Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
- Transcatheter Uterine Artery Embolization
- Transmyocardial/Periventricular Device Closure of Ventricular Septal Defects
- Transtympanic Micropressure for the Treatment of Ménière's Disease
- Treatment of Hyperhidrosis
- Treatment of Osteochondral Defects of the Knee and Ankle
- Treatment of Varicose Veins (Lower Extremities)
- Vagus Nerve Stimulation
- Viscocanalostomy and Canaloplasty



### **Human Organ and Bone Marrow/Stem Cell Transplants**

- Inpatient admissions for **ALL** solid organ and bone marrow/stem cell transplants (Including Kidney only transplants)
- All Outpatient services for the following:
  - ▶ Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
  - ▶ Donor Leukocyte Infusion

### **Out-of-Network Referrals:**

Out-of-Network Services for consideration of payment at Network benefit level (may be authorized, based on Network availability and/or Medical Necessity.)

### **Mental Health/Substance Abuse:**

#### **Pre-certification Required**

- Acute Inpatient Admissions
- Transcranial Magnetic Stimulation (TMS)
- Intensive Outpatient Therapy (IOP)
- Partial Hospitalization (PHP)
- Residential Care

#### **Out-of-Network Referrals:**

Out-of-Network Services for consideration of payment at Network benefit level (may be authorized, based on Network availability and/or medical necessity.)

**The following services do not require precertification, but are recommended for pre-determination of Medical Necessity due to the existence of post service claim review criteria and/or the potential cost of services to the Member if denied by for lack of Medical Necessity:** Procedures, equipment, and/or specialty infusion drugs which have Medically Necessary criteria determined by the Claims Administrator's Medical Policy or Clinical Guidelines.

Utilizing a Provider outside of the Network may result in significant additional financial responsibility for You, because Your health benefit plan cannot prohibit Out-of-Network Providers from billing You for the difference between the Provider's charge and the benefit the Plan provides.

The ordering Provider, facility or attending Physician should contact the Claims Administrator to request a Precertification or Predetermination review ("requesting Provider"). The Claims Administrator will work directly with the requesting Provider for the Precertification request. However, You may designate an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.



## Who is Responsible for Precertification?

Typically, Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, facility or attending Doctor (“requesting Provider”) will get in touch with the Claims Administrator to ask for a Precertification. However, You may request a Precertification or You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
Network, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI); Anthem Blue Cross (CA); Empire Blue Cross Blue Shield; Blue Cross Blue Shield of Georgia; and any future affiliated Blue Cross and/or Blue Shield plans resulting from a merger or acquisition by the Claims Administrator’s parent company.	Provider	<ul style="list-style-type: none"> <li>The Provider must get Precertification when required</li> </ul>
Out-of- Network/ Non-Participating	Member	<ul style="list-style-type: none"> <li>Member must get Precertification when required. (Call Member Services.)</li> <li>Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary.</li> </ul>
Blue Card Provider outside the service areas of the states listed in the column above and BlueCard Providers in other states not listed,	Member (Except for Inpatient Admissions)	<ul style="list-style-type: none"> <li>Member must get Precertification when required. (Call Member Services.)</li> <li>Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary.</li> <li><b>Blue Card Providers must obtain precertification for all Inpatient Admissions.</b></li> </ul>
<b>NOTE: For an Emergency Care admission, precertification is not required. However, you, your authorized representative or Doctor must tell the Claims Administrator no later than 2 business days after admission or as soon as possible within a reasonable period of time.</b>		

The Claims Administrator will utilize its clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section “Prescription Drugs Administered by a Medical Provider”. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The Claims Administrator reserves the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning Your request. To ask for this information, call the Precertification phone number on the back of Your Identification Card.

If You are not satisfied with the Plan’s decision under this section of Your benefits, please refer to the **Your Right To Appeal** section to see what rights may be available to You.

### Decision and Notice Requirements

The Claims Administrator will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on Federal laws. You may call the phone number on the back of your Identification Card for more details.

Type of Review	Timeframe Requirement for Decision and Notification
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request
Urgent Continued Stay/Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay/Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-urgent Continued Stay/Concurrent Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make a decision, the Claims Administrator will tell the requesting Provider of the specific information needed to finish the review. If the Claims Administrator does not get the specific information needed by the required timeframe, the Claims Administrator will make a decision based upon the information it has.

The Claims Administrator will notify You and Your Provider of its decision as required by Federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

### Important Information

From time to time certain medical management processes (including utilization management, case management, and disease management) may be waived, enhanced, changed or ended. An alternate benefit may be offered if in the Plan’s sole discretion, such change furthers the provision of cost effective, value based and/or quality services.

Certain qualifying Providers may be selected to take part in a program or a provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. Your claim may also be exempted from medical review if certain conditions apply.

Just because a process, Provider or Claim is exempted from the standards which otherwise would apply, it does not mean that this will occur in the future, or will do so in the future for any other Provider, claim or Member. The Plan may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs or a provider arrangement by contacting the Member Services number on the back of your Identification Card.

The Claims Administrator also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then the Claims Administrator may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

### **Health Plan Individual Case Management**

The Claims Administrator's individual health plan case management programs (Case Management) helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The Claims Administrator's programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

The Claims Administrator's Case Management programs are confidential and voluntary and are made available at no extra cost to You. These programs are provided by, or on behalf of and at the request of, Your health plan Case Management staff. These Case Management programs are separate from any Covered Services You are receiving.

If You meet program criteria and agree to take part, the Claims Administrator will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your authorized representative, treating Physician(s), and other Providers.

In addition, the Claims Administrator may assist in coordinating care with existing community-based programs and services to meet Your needs. This may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or Injury, the Plan may provide benefits for alternate care that is not listed as a Covered Service. The Plan may also extend Covered Services beyond the Benefit Maximums of this Plan. The Claims Administrator will make any recommendation of alternate or extended benefits to the Plan on a case-by-case basis, if at the Claims Administrator's discretion the alternate or extended benefit is in the best interest of You and the Plan and You or Your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to You or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Claims Administrator will notify You or Your authorized representative in writing.

## BENEFITS

**Payment terms apply to all Covered Services. Please refer to the Schedule of Benefits for details. All Covered Services must be Medically Necessary, whether provided through Network Providers or Out-of-Network Providers.**

### Acupuncture

Treatment of neuromusculoskeletal pain by an acupuncturist who acts within the scope of their license. Treatment involves using needles along specific nerve pathways to ease pain.

### Ambulance Service

Medically Necessary Ambulance Services are a Covered Service when:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

And one or more of the following criteria are met:

- For ground ambulance, You are taken:
  - From Your home, the scene of an accident or Medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital
  - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, You are taken:
  - From the scene of an accident or Medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital
  - Between a Hospital and an approved Facility.

Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. Emergency ground ambulance services do not require precertification and are allowed regardless of whether the Provider is a Network or Out-of-Network Provider.

Non-Emergency ambulance services are subject to Medical Necessity reviews by the Claims Administrator. When using an air ambulance, for non-Emergency transportation, the Claims Administrator reserves the right to select the air ambulance Provider. If you do not use the air ambulance Provider the Claims Administrator selects, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases the Claims Administrator may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or Injury by medical professionals from an ambulance service, even if You are not taken to a Facility.

Ambulance Services are not covered when another type of transportation can be used without endangering Your health. Ambulance Services for Your convenience or the convenience of Your family or Physician are not a Covered Service.

Other non-covered Ambulance Services include, but are not limited to, trips to:

- a Physician's office or clinic; or
- a morgue or funeral home.

### **Important Notes on Air Ambulance Benefits**

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger Your health and Your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if You are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if You are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if You are taken to a Physician's office or Your home.

### **Hospital to Hospital Transport**

If You are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger Your health and if the Hospital that first treats cannot give You the medical services You need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, You must be taken to the closest Hospital that can treat You. **Coverage is not available for air ambulance transfers simply because You, Your family, or Your Provider prefers a specific Hospital or Physician.**

### **Assistant Surgery**

Services rendered by an assistant surgeon are covered based on Medical Necessity.

### **Behavioral Health Care and Substance Abuse Treatment**

See the **Schedule of Benefits** for any applicable Deductible, Coinsurance/Copayment information. Coverage for the diagnosis and treatment of Behavioral Health Care and Substance Abuse Treatment on an Inpatient or outpatient basis will not be subject to Deductibles or Copayment/Coinsurance provisions that are less favorable than the Deductibles or Copayment/Coinsurance provisions that apply to a physical illness as covered under this Benefit Booklet.

Covered Services include the following:

- **Inpatient Services** in a Hospital or any facility that must be covered by law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and Detoxification.
- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:
  - observation and assessment by a psychiatrist weekly or more often; and
  - rehabilitation, therapy, and education.
- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, and Intensive Outpatient Programs.
- **Online Visits** when available in Your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions. Online visits are not covered from Providers other than those contracted with LiveHealth Online.

Examples of Providers from whom you can receive Covered Services include:

- Psychiatrist;
- Psychologist;
- Licensed Clinical Social Worker (L.C.S.W.);
- Mental health clinical nurse specialist;
- Licensed Marriage and Family Therapist (L.M.F.T.);
- Licensed Professional Counselor (L.P.C); or
- Any agency licensed by the state to give these services, when they have to be covered by law.

### **Breast Cancer Care**

Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Member. Follow-up visits are also included and may be conducted at home or at the Physician's office as determined by the attending Physician in consultation with the Member.

### **Breast Reconstructive Surgery**

Covered Services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.

### **Cardiac Rehabilitation**

Covered Services are provided as outlined in the **Schedule of Benefits**.

### **Clinical Trials**

Benefits include coverage for services, such as routine patient care costs, given to You as a participant in an approved clinical trial if the services are Covered Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
  - a. The National Institutes of Health.
  - b. The Centers for Disease Control and Prevention.
  - c. The Agency for Health Care Research and Quality.
  - d. The Centers for Medicare & Medicaid Services.
  - e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
  - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
    - i. The Department of Veterans Affairs.
    - ii. The Department of Defense.
    - iii. The Department of Energy.



2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require You to use a Network Provider to maximize Your benefits.

Routine patient care costs include items, services, and Drugs provided to You in connection with an approved clinical trial that would otherwise be covered by this Plan.

All other requests for clinical trials services, including requests that are not part of approved clinical trials will be reviewed according to the Claims Administrator's Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. The Plan reserves its right to exclude any of the following services:

1. The Experimental/Investigative item, device, or service; or
2. Items and services that are provided only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

### **Consultation Services**

Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury. Second surgical opinion consultations are covered.

Staff consultations required by Hospital rules are excluded. Referrals (the transfer of a patient from one Physician to another for treatment) are not consultations under this Plan.

### **Dental Services**

#### **Related to Accidental Injury**

Your Plan includes benefits for dental work required for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Member's condition. Injury as a result of chewing or biting is not considered an Accidental Injury except where the chewing or biting results from an act of domestic violence or directly from a medical condition.

Treatment must be completed within the timeframe shown in the **Schedule of Benefits**.

#### **Other Dental Services**

Your Plan also includes benefits for Hospital charges and anesthetics provided for dental care if the Member meets any of the following conditions:

- the Member is under the age of five (5);
- the Member has a severe impairment that requires hospitalization or general anesthesia for dental care; or
- the Member has a medical condition that requires hospitalization or general anesthesia for dental care.

## Diabetes

Equipment and outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes as prescribed by the Physician. Covered Services for outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

## Dialysis Treatment

The Plan covers Covered Services for Dialysis treatment. If applicable, the Plan will pay secondary to Medicare Part B, even if a Member has not applied for eligible coverage available through Medicare.

## Durable Medical Equipment

The Plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity, and applicable Precertification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Member's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- it can stand repeated use;
- it is manufactured solely to serve a medical purpose;
- it is not merely for comfort or convenience;
- it is normally not useful to a person not ill or injured;
- it is ordered by a Physician;
- the Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing Medical Necessity of any item; and
- it is related to the Member's physical disorder.

Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation will not be covered. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is Your responsibility.

## Emergency Services

### Life-threatening Medical Emergency or serious Accidental Injury.

Coverage is provided for Hospital emergency room care including a medical or behavioral health screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Medical Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical or behavioral health examination and treatment as are required to Stabilize the patient. Emergency Service care does not require any Prior Authorization from the Plan.

Stabilize means, with respect to an Emergency Medical Condition: to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

The Maximum Allowed Amount for emergency care from an Out-of-Network Provider will be the greatest of the following:



- the amount negotiated with Network Providers for the Emergency service furnished;
- the amount for the Emergency Service calculated using the same method the Claims Administrator generally uses to determine payments for Out-of-Network services but substituting the Network cost-sharing provisions for the Out-of-Network cost-sharing provisions; or
- the amount that would be paid under Medicare for the Emergency Service.

The Copayment and/or Coinsurance percentage payable for both Network and Out-of-Network are shown in the **Schedule of Benefits**.

### **General Anesthesia Services**

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure.

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- spinal or regional anesthesia;
- injection or inhalation of a drug or other agent (local infiltration is excluded).

Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only covered when billed by the supervising anesthesiologist.

### **Habilitative Services**

Benefits also include habilitative health care services and devices that help You keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or outpatient settings.

### **Home Health Care Services**

Home Health Care provides a program for the Member's care and treatment in the home. Your coverage is outlined in the **Schedule of Benefits**. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician. Services may be performed by either Network or Out-of-Network Providers.

#### **Some special conditions apply:**

- The Physician's statement and recommended program must be pre-certified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Note: Covered Services available under Home Health Care do NOT reduce outpatient benefits available under the Physical Therapy section shown in this Plan.
- A Member must be essentially confined at home.

#### **Covered Services:**

- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Member.
- Private Duty Nursing care;
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.

- Nutritional guidance when Medically Necessary.
- Administration or infusion of prescribed drugs.
- Oxygen and its administration.

**Covered Services for Home Health Care do not include:**

- food, housing, homemaker services, sitters, home-delivered meals;
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care;
- services and/or supplies which are not included in the Home Health Care plan as described;
- services of a person who ordinarily resides in the Member's home or is a member of the family of either the Member or Member's Spouse;
- any services for any period during which the Member is not under the continuing care of a Physician;
- convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the Member;
- any services or supplies not specifically listed as Covered Services;
- routine care and/or examination of a newborn child;
- dietician services;
- maintenance therapy;
- dialysis treatment; or
- purchase or rental of dialysis equipment.

**Hospice Care Services**

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- care from an interdisciplinary team with the development and maintenance of an appropriate plan of care;
- short-term Inpatient Hospital care when needed in periods of crisis or as respite care;
- skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse;
- social services and counseling services from a licensed social worker;
- nutritional support such as intravenous feeding and feeding tubes;
- Physical Therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist;
- pharmaceuticals, medical equipment, and supplies needed for the palliative care of Your condition, including oxygen and related respiratory therapy supplies; and
- bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties for one year after the Member's death.

Your Physician and Hospice medical director must certify that You are terminally ill and likely have less than 12 months to live. Your Physician must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Benefit Booklet.

## Hospital Services

You may receive treatment at a Network or an Out-of-Network Hospital. However, payment is significantly reduced if services are received at an Out-of-Network Hospital. Your Plan provides Covered Services when the following services are Medically Necessary.

### Network

#### Inpatient Services

- Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If You stay in a private room, the Maximum Allowed Amount is based on the Hospital's prevalent semiprivate rate. If You are admitted to a Hospital that has only private rooms, the Maximum Allowed Amount is based on the Hospital's prevalent room rate.

#### Service and Supplies

- Services and supplies provided and billed by the Hospital while You're an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also covered.
- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

#### Length of Stay

- Determined by Medical Necessity.

### Out-of-Network

#### Hospital Benefits

If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the **Schedule of Benefits** section.

## Hospital Visits

The Physician's visits to his or her patient in the Hospital. Covered Services are limited to one daily visit for each attending Physician specialty during the covered period of confinement.

## Human Organ and Tissue Transplant Services

### Notification

**To maximize Your benefits, You need to call the Claims Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. Your evaluation and work-up services must be provided by a Network Transplant Provider to receive the maximum benefits.**

Contact the Member Services telephone number on Your Identification Card and ask for the transplant coordinator. The Claims Administrator will then assist the Member in maximizing their benefits by providing coverage information including details regarding what is covered and whether any medical policies, network requirements or Benefit Booklet exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Member.

### Covered Transplant Benefit Period

At a Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Call the Claims Administrator for specific Network Transplant Provider details for services received at or coordinated by a Network Transplant Provider Facility.

At an Out-of-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts until the date of discharge.

### **Prior Approval and Precertification**

In order to maximize Your benefits, the Claims Administrator strongly encourages You to call its' transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. The Claims Administrator will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Member Services telephone number on the back of Your Identification Card **and ask for the transplant coordinator**. Even if the Claims Administrator issues a prior approval for the Covered Transplant Procedure, You or Your Provider must call the Claims Administrator's Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or outpatient setting.

Please note that there are instances where Your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

### **Transportation and Lodging**

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Claims Administrator when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the facility where Your Covered Transplant Procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the transplant recipient Member and one companion for an adult Member, or two companions for a child patient. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when claims are filed. Contact the Claims Administrator for detailed information. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

### **Licensed Speech Therapist Services**

Services must be ordered and supervised by a Physician as outlined in the **Schedule of Benefits**. Speech therapy is not covered when rendered for the treatment of Developmental Delay.

### **Maternity Care and Reproductive Health Services**

Covered Services are provided for Network Maternity Care as stated in the **Schedule of Benefits**. If You choose an Out-of-Network Provider, benefits are subject to the Deductible and percentage payable provisions as stated in the **Schedule of Benefits**.

Maternity benefits are provided for a female Teammate or female Spouse of the Teammate. Dependent daughter maternity is also covered.

Routine newborn nursery care is part of the mother's maternity benefits. Benefits are provided for well baby pediatrician visits performed in the Hospital.

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. (See "Changing Coverage (Adding a Dependent)" to add a newborn to Your coverage.)

Under Federal law, the Plan may not restrict the length of stay to less than the 48/96 hour periods or require Precertification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Member's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Member will have access to two post-discharge follow-up visits

within the 48 or 96 hour period. These visits may be provided either in the Physician's office or in the Member's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of Provider rendering the service will be made by the Member's attending Physician.

### **Abortion (Therapeutic or Elective)**

Your Plan includes benefits for a therapeutic abortion, which is an abortion recommended by a Provider that is performed to save the life or health of the mother, or as a result of incest or rape. Your Plan also provides benefits for an elective (voluntary) abortion, which is an abortion performed for reasons other than those described above.

### **Contraceptive Benefits**

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

### **Infertility Services**

Your Plan also includes benefits for the diagnosis and treatment of Infertility. Covered Services include diagnostic and exploratory procedures to determine whether a Member suffers from Infertility. This includes surgical procedures to correct any diagnosed disease or condition affecting the reproductive organs. This includes, but is not limited to, endometriosis, (tissue lining the uterus moves to other parts of the body), collapsed/clogged fallopian tubes or testicular failure. Covered fertilization services include artificial insemination, in-vitro fertilization, GIFT (gamete intrafallopian transfer), or ZIFT (zygote intrafallopian transfer) procedures. See the **Schedule of Benefits** for benefit limitations, Coinsurance and Copayment amounts.

### **Sterilization Services**

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or Injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.

### **Medical Care**

General diagnostic care and treatment of illness or Injury. Some procedures require Precertification.

### **Nutritional Counseling**

Nutritional counseling related to the medical management of a disease state as stated in the **Schedule of Benefits**.

### **Obesity**

Prescription Drugs and any other services or supplies for the treatment of obesity are not covered.

### **Online Visits**

When available in Your area, Your coverage will include online visits from a LiveHealth Online Provider. Covered Services include a medical consultation using the internet via a webcam, chat or voice. See **Schedule of Benefits** for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. For Behavioral Health and Substance Abuse Online Visits, see the "Behavioral Health Care and Substance Abuse Treatment" section. Online visits are not covered from Providers other than those contracted with LiveHealth Online. Non-Covered Services include, but are not limited to, communications used for:

- reporting normal lab or other test results;
- office appointment requests;
- billing, insurance coverage or payment questions;

- requests for referrals to Physicians outside of the online care panel;
- benefit precertification; and
- Physician to Physician consultation.

## Oral Surgery

Covered Services include only the following:

- Fracture of facial bones;
- Lesions of the mouth, lip, or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Plastic repair of the mouth or lip necessary to correct traumatic Injuries or congenital defects that will lead to functional impairments; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to sound natural teeth or structure occurring while a Member is covered by this Plan and performed within the timeframes shown in the **Schedule of Benefits** after the accident.

Although this Plan covers certain oral surgeries as listed above, many oral surgeries are not covered. Covered Services also include the following:

- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral/surgical correction of accidental injuries as indicated in the “Dental Services” section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

## Other Covered Services

Your Plan provides Covered Services when the following services are Medically Necessary:

- chemotherapy and radioisotope, radiation and nuclear medicine therapy;
- diagnostic x-ray and laboratory procedures;
- dressings, splints and casts when provided by a Physician;
- oxygen, blood and components, and administration;
- pacemakers and electrodes; or
- use of operating and treatment rooms and equipment.

## Out-of-Network Freestanding Ambulatory Facility

Any services rendered or supplies provided while You are a patient or receiving services at or from an Out-of-Network Freestanding Ambulatory Facility will be payable at the Maximum Allowed Amount.

## Out-of-Network Hospital Benefits

If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the **Schedule of Benefits** section.

## Outpatient CT Scans and MRIs

These services are covered at regular Plan benefits.

## Outpatient Hospital Services

The Plan provides Covered Services when the following outpatient services are Medically Necessary: pre-admission tests, surgery, diagnostic X-rays and laboratory services. Certain procedures require Precertification.



## Outpatient Surgery

Network Hospital outpatient department or Network Freestanding Ambulatory Facility charges are covered at regular Plan benefits. Benefits for treatment by an Out-of-Network Hospital are explained under “Hospital Services”.

## Physical Therapy, Occupational Therapy, Manipulation Therapy

Services by a Physician, a registered physical therapist (R.P.T.), a licensed occupational therapist (O.T.), or a licensed chiropractor (D.C.) as outlined in the **Schedule of Benefits**. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual Provider. No coverage is available when such services are necessitated by Developmental Delay.

## Physician Services

You may receive treatment from a Network or Out-of-Network Physician. However, payment is significantly reduced if services are received from an Out-of-Network Physician. Such services are subject to Your Deductible and Out-of-Pocket requirements. Consultations between your Primary Care Physician and a Specialty Care Physician are included, when approved by Anthem.

## Preventive Care

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA). This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when You use a Network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under Diagnostic services instead of this benefit, if the coverage does not fall within ACA-recommended preventive services.

Covered Services fall under the following broad groups:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
  - a. breast cancer;
  - b. cervical cancer;
  - c. colorectal cancer;
  - d. high blood pressure;
  - e. Type 2 Diabetes Mellitus;
  - f. Cholesterol;
  - g. child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
  - a. Women’s contraceptives, sterilization procedures, and counseling. This includes Generic oral contraceptives, injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Brand Drugs will be covered as a Preventive Care benefit when Medically Necessary according to Your attending

Provider, otherwise they will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."

- b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
  - c. Gestational diabetes screening.
5. Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
- a. counseling;
  - b. Prescription Drugs obtained at a Retail or Home Delivery (Mail Order) Pharmacy; and
  - c. Nicotine replacement therapy products obtained at a Retail or Home Delivery (Mail Order) Pharmacy, when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

Prescription drugs and OTC items are limited to a no more than 180 day supply per 365 days.

6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:
- a. aspirin;
  - b. folic acid supplement;
  - c. vitamin D supplement; and
  - d. bowel preparations.

Please note that certain age and gender and quantity limitations apply.

You may call Member Services using the number on Your Identification Card for additional information about these services or view the Federal government's web sites, <http://www.healthcare.gov/center/regulations/prevention.html>, <http://www.ahrq.gov>, and <http://www.cdc.gov/vaccines/acip/index.html>.

## **Prosthetic Appliances**

Prosthetic devices to improve or correct conditions resulting from Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

Prosthetic devices include: artificial limbs and accessories; artificial eyes, one pair of glasses or contact lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes); and external breast prostheses used after breast removal.

The following items are excluded: corrective shoes; dentures; replacing teeth or structures directly supporting teeth (except to correct traumatic injuries); electrical or magnetic continence aids (either anal or urethral); and implants for cosmetic purposes except for reconstruction following a mastectomy.

## **Reconstructive Surgery**

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, Injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.



**Note:** Coverage for reconstructive services does not apply to orthognathic surgery. See the “Oral Surgery” section above for that benefit.

### **Retail Health Clinic**

Benefits are provided for Covered Services received at a Retail Health Clinic.

### **Skilled Nursing Facility Care**

Benefits are provided as outlined in the **Schedule of Benefits**. This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- a favorable prognosis;
- a reasonably predictable recovery time; and
- services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the Member's residence.

Covered Services include:

- semiprivate or ward room charges including general nursing service, meals, and special diets. If a Member stays in a private room, this Plan pays the Semiprivate Room rate toward the charge for the private room;
- use of special care rooms;
- pathology and radiology;
- Physical or speech therapy;
- oxygen and other gas therapy;
- drugs and solutions used while a patient; or
- gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician's continuous care and 24-hour-a-day nursing care.

Benefits will not be provided when:

- a Member reaches the maximum level of recovery possible and no longer requires other than routine care;
- care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- no specific medical conditions exist that require care in a Skilled Nursing Facility; or
- the care rendered is for other than Skilled Convalescent Care.

### **Surgical Care**

Surgical procedures including the usual pre- and post-operative care. Some procedures require Precertification.

### **Treatment of Accidental Injury in a Physician's Office**

All outpatient surgical procedures related to the treatment of an Accidental Injury, when provided in a Physician's office, will be covered under the Member's Physician's office benefit if services are rendered by a Network Provider. Services rendered by Out-of-Network Providers are subject to Deductible and Coinsurance requirements.

### **Prescription Drugs Administered by a Medical Provider**

This Plan covers Prescription Drugs including Specialty Drugs, that must be administered to You as part of a Doctor's visit, home care visit, or at an outpatient facility when they are Covered Services. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any Drug that

must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to You in a medical setting. Benefits for Drugs that You inject or get through Your Pharmacy benefits (i.e., self-administered Drugs) are not covered under this section. Benefits for those Drugs are described in the “Prescription Drug Benefits at a Retail or Home Delivery (Mail Service) Pharmacy” section.

### **Important Details About Prescription Drug Coverage**

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, Your prescribing Doctor may be asked to give more details before the Plan decides if the Prescription Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, the Claims Administrator has established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,
- Use of an Anthem Prescription Drug List (a formulary developed by the Claims Administrator which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

### **Precertification**

Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. The Claims Administrator will give the results of the Plan’s decision to both You and Your Provider.

For a list of Prescription Drugs that need precertification, please call the phone number on the back of Your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with the Claims Administrator to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Please refer to the section **Health Care Management - Precertification** for more details.

If precertification is denied You have the right to file an appeal as outlined in the **Your Right To Appeal** section of this Benefit Booklet.

### **Designated Pharmacy Provider**

The Plan in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. A Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the Network Provider must have signed a Designated Pharmacy Provider Agreement with the Claims Administrator. You or Your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to You or Your Provider and administered in Your Provider’s office, You and Your Provider are required to order from a Designated Pharmacy Provider. A Patient

Care coordinator will work with You and Your Provider to obtain Precertification and to assist shipment to Your Provider's office.

You may also be required to use a Designated Pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions such as Hemophilia. The Plan reserves the right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to You. The Plan may from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug, if in the Plan's discretion, such change can help provide cost effective, value based and/or quality services.

If You are required to use a Designated Pharmacy Provider and You choose not to obtain Your Prescription Drug from a Designated Pharmacy Provider, coverage will be provided at the Out-of-Network level.

You can get the list of the Prescription Drugs covered under this section by calling Member Services at the phone number on the back of Your Identification Card or check the Claims Administrator's website at [www.anthem.com](http://www.anthem.com).

## **Prescription Drug Benefits at a Retail or Home Delivery (Mail Service) Pharmacy**

**See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.**

Benefits for Prescription Drugs, including Specialty Drugs, which are administered to You by a medical Provider in a medical setting (e.g., Physician's office, home care visit, or outpatient facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

Your plan also includes benefits for Prescription Drugs You get at a Retail or Mail Order Pharmacy. The Pharmacy benefits available to You under this Plan are managed by the Claims Administrator's Pharmacy Benefits Manager (PBM). The PBM is a pharmacy benefits management company with which the Claims Administrator contracts to manage Your Pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a Home Delivery (Mail Service) Pharmacy, and provides clinical management services.

The management and other services the PBM provides include, among others, making recommendations to, and updating the covered Prescription Drug list (also known as a Formulary) establishing a network of retail pharmacies and operating a Home Delivery (Mail Service) Pharmacy. The PBM, in consultation with the Claims Administrator also provides services to promote and enforce the appropriate use of Pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regimens; Drug interactions or Drug/pregnancy concerns.

You may request a copy of the covered Prescription Drug list by calling the Member Services telephone number on Your Identification Card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the PBM and/or the Claims Administrator can determine Medical Necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer. Covered Services will be limited based on Medical Necessity, quantity, and/or age limits established by the Plan or utilization guidelines.

Prescription Drug benefits may require prior authorization to determine if Your Drugs should be covered. Your Network Pharmacist will be told if Prior Authorization is required and if any additional details are needed for the Plan to decide benefits.

### **Prior Authorization**

Prescribing Providers must obtain prior authorization in order for You to get benefits for certain Drugs. At times Your Provider will initiate a prior authorization on Your behalf before Your Pharmacy fills Your Prescription. At other times, the Pharmacy may make You or Your Provider aware that a prior authorization or other information is needed. In order to determine if the Prescription drug is eligible for coverage, the Claims Administrator has established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,
- Use of a Prescription Drug List (as described below).

You or Your Provider can get the list of the Drugs that require prior authorization by calling Member Services at the phone number on the back of Your Identification Card or check the Claims Administrator's website at [www.anthem.com](http://www.anthem.com). The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with the Claims Administrator to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

The Plan may, from time to time, waive, enhance, change or end certain prior authorization and/or offer alternate benefits, if in its sole discretion, such change furthers the provision of cost effective, value based and/or quality services.

If prior authorization is denied You have the right to file an appeal as outlined in the **Your Right To Appeal** section of this Benefit Booklet.

The Plan keeps a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time. The Plan may require You or Your doctor to order certain Specialty Drugs from the PBM's Specialty Pharmacy

When you use the PBM's Specialty Pharmacy its patient care coordinator will work with You and Your Doctor to get prior authorization and to ship Your Specialty Drugs to Your home or Your preferred address. Your patient care coordinator will also tell You when it is time to refill Your prescription.

You can get the list of covered Specialty Drugs by calling Member Services at the phone number on the back of Your Identification Card or check the Claims Administrator's website at [www.anthem.com](http://www.anthem.com).

### **Maintenance Pharmacy**

You may also obtain a 90-day supply of Maintenance Medications from a Maintenance Pharmacy. A Maintenance Medication is a Drug You take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If You are not sure the Prescription Drug You are taking is a Maintenance Medication or need to determine if Your Pharmacy is a Maintenance Pharmacy, please call Member Services at the number on the back of Your Identification Card or check the Claims Administrator's website at [www.anthem.com](http://www.anthem.com) for more details.

### **Covered Prescription Drug Benefits**

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under Federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and You must get them from a licensed Pharmacy. Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

Benefits are available for the following:

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive Drugs are covered when obtained through an eligible Pharmacy. Emergency contraceptives, including Plan B are covered. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.
- Certain supplies and equipment obtained by Home Delivery (Mail Service) or from a Network Pharmacy (such as those for diabetes and asthma) are covered without any Copayment/Coinsurance. Contact the Plan to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Home Delivery (Mail Service) or from a Network Pharmacy then they are covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits.
- Self-administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit.
- Flu Shots (including administration). These products will be covered under the "Preventive Care" benefit.
- Immunizations (including administration) required by the "Preventive Care" benefit.
- Prescription Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products. Benefits include FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older. These services will be covered under the "Preventive Care" benefit. Please see that section for further details.
- Compound Drugs when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, and require a Prescription to dispense, and are not essentially the same as an FDA approved product from a Drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
- Treatment of Onchomycosis (toenail fungus).
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility Drugs.

### **Non Covered Prescription Drug Benefits (please also see the Exclusions section of this Benefit Booklet for other Non-Covered Services)**

- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This Exclusion does not apply to over-the-counter products that the Plan must cover under Federal law with a Prescription.
- Off label use, except as otherwise prohibited by law or as approved by the Plan or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA
- Charges for the administration of any Drug.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including, but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.
- Any Drug which is primarily for weight loss.
- Drugs not requiring a Prescription by Federal law (including Drugs requiring a Prescription by state law, but not by Federal law), except for injectable insulin.
- Drugs in quantities, which exceed the limits established by the Plan, or which exceed any age limits established by the Plan.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Plan through Prior Authorization.
- Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, and require a Prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a Drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact the Plan for additional information on these Drugs.
- Prescription Drugs prescribed by a Provider that does not have the necessary qualifications and including certifications as determined by the Claims Administrator.
- Drugs that do not need a prescription by Federal law (including Drugs that need a prescription by state law, but not by Federal law), except for injectable insulin.
- Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
- Charges for services not described in Your medical records.
- Services prescribed, ordered, referred by or given by a Member of Your immediate family, including Your spouse, child, brother, sister, parent, in-law, or self.
- Services determined to not be Medically Necessary. This includes services that do not meet medical policy, clinical coverage, or benefit policy guidelines.
- Nutritional and/or dietary supplements, except as described in this Benefit Booklet or that must be covered by law. This Exclusion includes, but is not limited to, *nutritional formulas and dietary supplements that You can buy over the counter* and those You can get without a written Prescription or from a licensed pharmacist.

### **Deductible/Coinsurance/Copayment**

Each Prescription Order may be subject to Coinsurance/Copayment. If the Prescription Order includes more than one covered Drug, a separate Coinsurance/Copayment will apply to each covered Drug. Your Prescription Drug Coinsurance/Copayment will be the lesser of Your scheduled Copayment/Coinsurance amount or the Maximum Allowed Amount. Please see the **Schedule of Benefits** for any applicable Coinsurance/Copayment. If You receive Covered Services from an Out-of-Network Pharmacy, a Coinsurance/Copayment amount may also apply.



### Days Supply

Certain day supply limits apply to Prescription Drugs as listed in the **Schedule of Benefits**. In most cases, You must use a certain amount of your prescription before it can be refilled. In some cases the Plan may let You get an early refill. For example, the Plan may let You refill your prescription early if it is decided that You need a larger dose. The Claims Administrator will work with the Pharmacy to decide when this should happen.

If You are going on vacation and You need more than the day supply allowed, You should ask Your pharmacist to call the PBM and ask for an override for one early refill. If You need more than one early refill, please call Member Services at the number on the back of Your Identification Card.

### Mandatory Generic

If You choose a Brand-Name Drug over a Generic Drug, regardless of whether a generic equivalent is available and even if the Physician orders the drug to be “dispensed as written”, You will be responsible for the Copayment/Coinsurance for the Brand-Name Drug outlined in the **Schedule of Benefits**.

If You do not purchase a Generic Prescription Drug, when available, You must also pay the difference between the cost of the Generic Prescription Drug and the Brand Name Prescription Drug unless Your Physician has specified “dispensed as written”.

### Formulary

The Plan follows a drug Formulary in determining payment and Covered Services. You will be responsible for an additional Copayment amount depending on whether a Formulary or non-Formulary drug is obtained. Please see the **Schedule of Benefits**.

### Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products or multi-source Brand Drugs.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products or multi-source Brand Drugs.

Drugs are assigned to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. The Plan decides coverage for doses and administration (i.e., oral, injection, topical, or inhaled). The Plan may cover one form of administration instead of another, or put other forms of administration in a different tier.

### Special Programs

Except when prohibited by Federal regulations (such as HSA rules), from time to time the Claims Administrator or the PBM may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, Generic Drugs, Home Delivery (Mail Service) Drugs, over the counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain Drugs or preferred products for a limited period of time.

### Payment of Benefits

The amount of benefits paid is based upon whether You receive the Covered Services from a Network Pharmacy, an Out-of-Network Pharmacy, or the PBM's Home Delivery (Mail Service) Program. It is also based upon which Tier the Claims Administrator has classified the Prescription Drug. Please see the **Schedule of Benefits** for the applicable amounts, and for applicable limitations on number of days supply.

The Claims Administrator retains the right at the Claims Administrator's discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical or inhaled) and may cover one form of administration and exclude or place other forms of administration on other Tiers.

The amounts for which You are responsible are shown in the **Schedule of Benefits**. No payment will be made by the Plan for any Covered Service unless the negotiated rate exceeds any applicable Copayment/Coinsurance for which You are responsible.

Your Copayment(s)/Coinsurance amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Plan from Drug manufacturers or similar vendors. For Covered Services provided by a Network Pharmacy or through the PBM's Home Delivery (Mail Service), You are responsible for all Copayment/Coinsurance amounts.

For Covered Services provided by an Out-of-Network Pharmacy, You will be responsible for the amount(s) shown in the **Schedule of Benefits**. This is based on the Maximum Allowed Amount.

### How to Obtain Prescription Drug Benefits

How You obtain Your benefits depends upon whether You go to a Network or an Out-of-Network Pharmacy.

**Network Pharmacy** – Present Your written Prescription order from Your Physician and Your Identification Card to the pharmacist at a Network Pharmacy. The Pharmacy will file Your claim for You. You will be charged at the point of purchase for applicable Copayment/Coinsurance amounts. If You do not present Your Identification Card, You will have to pay the full retail price of the Prescription. If You do pay the full charge, ask Your pharmacist for an itemized receipt and submit it to the Plan with a written request for refund.

**Important Note:** If it is determined that You may be using Controlled Substance Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of Network Providers for Controlled Substance Prescriptions may be limited. If this happens, the Plan may require You to select a single Network Provider that will provide and coordinate all Controlled Substance Prescriptions. Benefits for Controlled Substance Prescriptions will only be paid if You use the single Network Provider. The Claims Administrator will contact You if it is determined that use of a single Network Provider is needed and give You options as to which Network Provider You may use. If You do not select one of the Network Providers offered within 31 days, a single Network Provider will be selected for You. If You disagree with the Plan's decision, You may ask for reconsideration as it is outlined in the **Your Right to Appeal** section of this Benefit Booklet.

**Specialty Drugs** - You or Your Physician can order Your Specialty Drugs directly from a Specialty Network Pharmacy, simply call the Member Services telephone number on the back of Your Identification Card. If You or Your Physician orders Your Specialty Drugs from a Specialty Network Pharmacy, You will be assigned a patient care coordinator who will work with You and Your Physician to obtain Prior Authorization and to coordinate the shipping of Your Specialty Drugs directly to You or Your Physician's office. Your patient care coordinator will also contact You directly when it is time to refill Your Specialty Drug Prescription.



**Out-of-Network Pharmacy** – You are responsible for payment of the entire amount charged by the Out-of-Network Pharmacy. You must submit a Prescription Drug claim form to the Plan for reimbursement consideration. These forms are available from the Claims Administrator or from the Employer. You must complete the top section of the form and ask the Out-of-Network Pharmacy to complete the bottom section. If for any reason the bottom section of this form cannot be completed by the pharmacist, You must attach an itemized receipt to the claim form and submit to the Plan or the PBM. The itemized receipt must show:

- name and address of the Out-of-Network Pharmacy;
- patient's name;
- prescription number;
- date the Prescription was filled;
- name of the Drug;
- cost of the Prescription; and,
- quantity of each covered Drug or refill dispensed.

You are responsible for the amount shown in the **Schedule of Benefits**. This is based on the Maximum Allowed Amount as determined by Anthem or the PBM's normal or average contracted rate with network pharmacies on or near the date of service.

**The Home Delivery (Mail Service) Program** – Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written Prescriptions from Your Physician, or have Your Physician fax the Prescription to the PBM's Home Delivery (Mail Service). Your Physician may also phone in the Prescription to the PBM's Home Delivery (Mail Service) Pharmacy. You will need to submit the applicable Coinsurance and/or Copayment amounts to the PBM's Home Delivery (Mail Service) when You request a Prescription or refill.

## LIMITATIONS AND EXCLUSIONS

These limitations and exclusions apply even if a qualified practitioner has performed or prescribed a Medically Necessary procedure, treatment or supply. This does not prevent your qualified practitioner from providing or performing the procedure, treatment or supply. Regardless, the procedure, treatment or supply will not be a covered expense.

1. Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military facilities except as required by law.
2. Services for Custodial Care.
3. Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care.
4. Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this Benefit Booklet.
5. Charges for treatment received before coverage under this option began or after it is terminated.
6. Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the Claims Administrator's judgment, Experimental or Investigational for the diagnosis for which the Member is being treated.
7. Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury, as determined by the Claims Administrator.
8. Foot care only to improve comfort or appearance, routine care of corns, calluses, toenail (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Members with impaired circulation to the lower extremities.
9. Shoe inserts, orthotics (will be covered if prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary).
10. Treatment where payment is made by any local, state, or Federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which You as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
11. For which benefits are payable under Medicare Parts A and/or B or would have been payable if You had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in **General Information**. If You do not enroll in Medicare Part B when You are eligible, You may have large Out-of-Pocket costs. Please refer to Medicare.gov for more details on when You should enroll and when You are allowed to delay enrollment without penalties.
12. Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.
13. Court-ordered services, or those required by court order as a condition of parole or probation, unless Medically Necessary and approved by the Plan.
14. Outpatient prescription drugs prescribed by a Physician and purchased or obtained from a retail pharmacy or retail pharmacist or a mail service pharmacy are excluded. These may be covered by a

separate drug card program but not under this medical plan. Although coverage for outpatient Prescription Drugs obtained from a retail pharmacy or pharmacist or mail service Pharmacy is excluded, certain Prescription Drugs are covered under your medical benefits when rendered in a Hospital, in a Physician's office, or as part of a Home Health Care benefit. Therefore, this exclusion does not apply to prescription drugs provided as Ancillary Services during an Inpatient stay or an Outpatient Surgical procedure; to prescription drugs used in conjunction with a Diagnostic Service; Chemotherapy performed in the office; home infusion or home IV therapy, nor drugs administered in your Physician's office.

15. Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.
16. Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet The Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.
17. Vitamins, minerals and food supplements, as well as vitamin injections not determined to be Medically Necessary in the treatment of a specific illness. Nutritional supplements, services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be Medically Necessary.
18. Services for Hospital confinement primarily for diagnostic studies.
19. Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, except for reconstructive surgery following a mastectomy or when Medically Necessary to correct damage caused by an accident, an injury or to correct a congenital defect.
20. Donor Search/Compatibility, except as otherwise indicated.
21. Hearing aids, hearing devices or examinations for prescribing or fitting them.
22. Contraceptive Drugs, except for any above stated covered contraceptive devices.
23. Hair transplants, hairpieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth.
24. Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, applied behavioral analysis, or educational interventions, except as expressly provided in this Benefit Booklet.
25. Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
26. Christian Science practitioner services.
27. Services and supplies for smoking cessation programs and treatment of nicotine addiction, including gum and patches to eliminate or reduce the dependency on or addiction to tobacco and tobacco products unless otherwise required by law.
28. Services provided in a halfway house.
29. Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made; services provided to the Member by a local, state or Federal government agency, or by a public school system or school district, except when the plan's benefits must be provided by law; services if the Member is not required to pay for them or they are provided to the Member for free.
30. Services or supplies provided by a member of your family or household.

31. Charges or any portion of a charge in excess of the Maximum Allowed Amount as determined by the Claims Administrator.
32. Fees or charges made by an individual, agency or facility operating beyond the scope of its license.
33. Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.
34. Services for any form of telecommunication, unless otherwise stated by the Plan.
35. Charges for any of the following:
  - a. Failure to keep a scheduled visit;
  - b. Completion of claim forms or medical records or reports unless otherwise required by law;
  - c. For Physician or Hospital's stand-by services;
  - d. For holiday or overtime rates.
  - e. Membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
  - f. Specific medical reports including those not directly related to the treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
36. Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available.
37. Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, consumer wearable/personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications. Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is Your responsibility. Reversal of vasectomy or reversal of tubal ligation.
38. Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and actinic changes and/or which are performed as a treatment for acne.
39. Services for outpatient therapy or rehabilitation other than those specifically listed as covered in this Benefit Booklet. Excluded forms of therapy include, but are not limited to, primal therapy, chelation therapy, Rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy and boot camp therapy.
40. Vision care services and supplies, including but not limited to eyeglasses, contact lenses and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery or for soft contact lenses due to a medical condition, i.e. diabetes.
41. Vision surgery related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
42. Services for weight loss programs, services and supplies. Weight loss programs include, but are not limited to, commercial weight loss programs (Weight Watcher, Jenny Craig, and LA Weight Loss).

43. Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
44. Vein Treatment - Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

## CLAIMS PAYMENT

Providers who participate in the BlueCard® PPO Network have agreed to submit claims directly to the local Blue Cross and/or Blue Shield plan in their area. Therefore if the BlueCard® PPO Network Hospitals, Physicians and ancillary Providers are used, claims for their services will generally not have to be filed by the Member. In addition, many Out-of-Network Hospitals and Physicians will also file claims if the information on the Blue Cross and Blue Shield Identification Card is provided to them. If the Provider requests a claim form to file a claim, a claim form can be obtained by contacting Your local Human Resources Department or by visiting [www.anthem.com](http://www.anthem.com).

Please note You may be required to complete an authorization form in order to have Your claims and other personal information sent to the Claims Administrator when You receive care in foreign countries. Failure to submit such authorizations may prevent foreign providers from sending Your claims and other personal information to the Claims Administrator.

### How to File Claims

Under normal conditions, the Claims Administrator should receive the proper claim form within 12 months after the service was provided. This section of the Benefit Booklet describes when to file a benefits claim and when a Hospital or Physician will file the claim for You.

Each person enrolled through the Plan receives an Identification Card. Remember, in order to receive full benefits, You must receive treatment from a Network Provider. When admitted to a Network Hospital, present Your Identification Card. Upon discharge, You will be billed only for those charges not covered by the Plan.

When You receive Covered Services from a Network Physician or other Network licensed health care provider, ask him or her to complete a claim form. Payment for Covered Services will be made directly to the Provider.

For health care expenses other than those billed by a Network Provider, use a claim form to report Your expenses. You may obtain these from Your Employer or the Claims Administrator. Claims should include Your name, Plan and Group numbers exactly as they appear on Your Identification Card. Attach all bills to the claim form and file directly with the Claims Administrator. Be sure to keep a photocopy of all forms and bills for Your records. The address is on the claim form.

Save all bills and statements related to Your illness or Injury. Make certain they are itemized to include dates, places and nature of services or supplies.

### Maximum Allowed Amount

#### General

This section describes how the Claims Administrator determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Out-of-Network Providers is based on this Plan's Maximum Allowed Amount for the Covered Service that You receive. Please see the "Inter-Plan Arrangements" section for additional information.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet the Plan's definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in Your Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. In addition, when You receive Covered Services from an Out-of-Network Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When You receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, Your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

#### **Provider Network Status**

The Maximum Allowed Amount may vary depending upon whether the Provider is a Network Provider or an Out-of-Network Provider.

A Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence or other closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. Please call Member Services for help in finding a Network Provider or visit [www.anthem.com](http://www.anthem.com).

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services You receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Plan will be one of the following as determined by the Claims Administrator:

1. An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established at its' discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or



2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, the Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care; or
4. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but contracted for other products with the Claims Administrator are also considered Out-of-Network. For this Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount.

For Covered Services rendered outside the Claims Administrator's Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating provider fee schedule/rate or the pricing arrangements required by applicable state or Federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing the Plan would use if the healthcare services had been obtained within the Claims Administrator's Service Area, or a special negotiated price.

Unlike Network Providers, Out-of-Network Providers may send You a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower Out-of-Pocket costs to You. Please call Member Services for help in finding a Network Provider or visit the Claims Administrator's website at [www.anthem.com](http://www.anthem.com).

Member Services is also available to assist You in determining this Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist You, You will need to obtain from Your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out-of-Pocket responsibility. Although Member Services can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted by the Provider.

**For Prescription Drugs:** The Maximum Allowed Amount is the amount determined by the Claims Administrator using Prescription Drug cost information provided by the Pharmacy Benefits Manager (PBM).

### **Member Cost Share**

For certain Covered Services and depending on Your plan design, You may be required to pay a part of the Maximum Allowed Amount as Your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether You received services from a Network or Out-of-Network Provider. Specifically, You may be required to pay higher cost sharing amounts or may have limits on Your benefits when using Out-of-Network Providers. Please see the



**Schedule of Benefits** in this Benefit Booklet for Your cost share responsibilities and limitations, or call Member Services to learn how this Plan's benefits or cost share amounts may vary by the type of Provider You use.

The Plan will not provide any reimbursement for Non-Covered Services. You may be responsible for the total amount billed by Your Provider for Non-Covered Services, regardless of whether such services are performed by a Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of this Benefit Booklet and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances You may only be asked to pay the lower Network cost sharing amount when You use an Out-of-Network Provider. For example, if You go to a Network Hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or facility, You will pay the Network cost share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The Claims Administrator and/or its designated pharmacy benefits manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers, distributors, and/or similar vendors, which may be related to certain Prescription Drug purchases under this Plan and which positively impact the cost effectiveness of Covered Services. These amounts are retained by the Claims Administrator. These amounts will not be applied to Your Deductible, if any, or taken into account in determining Your Copayment or Coinsurance.

### **Authorized Services**

In some circumstances, such as where there is no Network Provider available for the Covered Service, the Plan may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider. In such circumstance, You must contact the Claims Administrator in advance of obtaining the Covered Service. The Plan also may authorize the Network cost share amounts to apply to a claim for Covered Services if You receive Emergency services from an Out-of-Network Provider and are not able to contact the Claims Administrator until after the Covered Service is rendered. If the Plan authorizes a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Member Services for Authorized Services information or to request authorization.

### **Services Performed During Same Session**

The Plan may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to the Plan's Maximum Allowed Amount. If services are performed by Out-of-Network Providers, then You are responsible for any amounts charged in excess of the Plan's Maximum Allowed Amount with or without a referral or regardless if allowed as an Authorized Service. Contact the Claims Administrator for more information.

### **Processing Your Claim**

You are responsible for submitting Your claims for expenses not normally billed by and payable to a Hospital or Physician. Always make certain You have Your Identification Card with You. Be sure Hospital or Physician's office personnel copy Your name, and identification numbers (including the 3-letter prefix) accurately when completing forms relating to Your coverage.

### **Timeliness of Filing for Member Submitted Claims**

To receive benefits, a properly completed claim form with any necessary reports and records must be filed by You within 12 months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, You will be notified of the reason for the delay and will receive a list of all information needed

to continue processing Your claim. After this data is received, the Claims Administrator will complete claims processing. No request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

### Necessary Information

In order to process Your claim, the Claims Administrator may need information from the Provider of the service. As a Member, You agree to authorize the Physician, Hospital, or other Provider to release necessary information.

The Claims Administrator will consider such information confidential. However, the Plan and the Claims Administrator have the right to use this information to defend or explain a denied claim.

### Claims Review

The Claims Administrator has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balance billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

### Notice of Claim & Proof of Loss

After You get Covered Services, we must receive written notice of Your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

In certain cases, You may have some extra time to file a claim. If we did not get Your claim within 90 days, but it is sent in as soon as reasonably possible and within one year after the 90-day period ends (i.e., within **12 months**), You may still be able to get benefits. **However, any claims, or additional information on claims, sent in more than 12 months after you get Covered Services will be denied, unless an extension is required by Federal law.**

### Explanation of Benefits

After You receive medical care, You will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement sent by the Claims Administrator, to help You understand the coverage You are receiving. The EOB shows:

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by Your coverage;
- the amount for which You are responsible (if any); and
- general information about Your appeals rights and for ERISA plans, information regarding the right to bring an action after the appeals process.

### Inter-Plan Arrangements

#### Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You access healthcare services outside the geographic area the Claims Administrator serves (the Anthem "Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of the Anthem Service Area, You will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield

Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. Explained below is how both kinds of Providers are paid.

### **Inter-Plan Arrangements Eligibility – Claim Types**

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that You obtain from a Pharmacy and most dental or vision benefits.

### **A. BlueCard<sup>®</sup> Program**

Under the BlueCard<sup>®</sup> Program, when You receive Covered Services within the geographic area served by a Host Blue, the Claims Administrator will still fulfill its contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When You receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount You pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to the Claims Administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price the Plan used for Your claim because they will not be applied after a claim has already been paid.

### **B. Negotiated (non-BlueCard Program) Arrangements**

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process Your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount You pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Anthem by the Host Blue.

### **C. Special Cases: Value-Based Programs**

#### *BlueCard<sup>®</sup> Program*

If You receive Covered Services under a Value-Based Program inside a Host Blue's Service Area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

#### *Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements*

If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Employer on Your behalf, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

### **D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees**

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, the Plan will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

#### **E. Nonparticipating Providers Outside the Claims Administrator's Service Area**

1. The pricing method used for nonparticipating provider claims incurred outside the Anthem Service Area is described in **Claims Payment**.

#### **F. Blue Cross Blue Shield Global Core<sup>®</sup> Program**

If You plan to travel outside the United States, call Member Services to find out Your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health Identification Card with You.

When You are traveling abroad and need medical care, You can call the Blue Cross Blue Shield Global Core Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or You can call them collect at 804-673-1177.

If You need inpatient hospital care, You or someone on Your behalf, should contact the Claims Administrator for preauthorization. Keep in mind, if You need Emergency medical care, go to the nearest hospital. There is no need to call before You receive care.

Please refer to the **Health Care Management – Precertification** section in this Booklet for further information. You can learn how to get preauthorization when You need to be admitted to the hospital for Emergency or non-emergency care.

#### **How Claims are Paid with Blue Cross Blue Shield Global Core**

In most cases, when You arrange inpatient hospital care with Blue Cross Blue Shield Global Core, claims will be filed for You. The only amounts that You may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When You need Blue Cross Blue Shield Global Core claim forms You can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core Center at the numbers above; or
- Online at [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com).

You will find the address for mailing the claim on the form.

#### **Unauthorized Use of Identification Card**

If You permit Your Identification Card to be used by someone else or if You use the card before coverage is in effect or after coverage has ended, You will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage. Fraudulent statements on enrollment forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Member's coverage. This includes fraudulent acts to obtain medical services and/or Prescription Drugs.

## Assignment

You authorize the Claims Administrator, in its own discretion and on behalf of the Employer, to make payments directly to Providers for Covered Services. In no event, however, shall the Plan's right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. The Claims Administrator also reserves the right, in its own discretion, to make payments directly to You as opposed to any Provider for Covered Service. In the event that payment is made directly to You, You have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Employer's Plan), or that person's custodial parent or designated representative. Any payments made by the Claims Administrator (whether to any Provider for Covered Service or You) will discharge the Employer's obligation to pay for Covered Services. You cannot assign Your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.]

The coverage, rights, and benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and/or law, sue or otherwise begin legal action, or request Plan documents or any other information that a Participant or beneficiary may request under ERISA, if subject to ERISA. Any assignment made without written consent from the Plan will be void and unenforceable.

Once a Provider performs a Covered Service, the Claims Administrator will not honor a request to withhold payment of the claims submitted.

The coverage and any benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above.

## Questions About Coverage or Claims

If You have questions about Your coverage, contact Your Plan Administrator or the Claims Administrator's Member Services Department. Be sure to always give Your Member identification number.

When asking about a claim, give the following information:

- identification number;
- patient's name and address;
- date of service and type of service received; and
- Provider name and address (Hospital or Physician).

To find out if a Hospital or Physician is a Network Provider, call them directly or call the Claims Administrator.

The Plan does not supply You with a Hospital or Physician. In addition, neither the Plan nor the Claims Administrator is responsible for any Injuries or damages You may suffer due to actions of any Hospital, Physician or other person. In order to process Your claims, the Claims Administrator or the Plan Administrator may request additional information about the medical treatment You received and/or other group health insurance You may have. This information will be treated confidentially.

An oral explanation of Your benefits by a Teammate of the Claims Administrator, Plan Administrator or Plan Sponsor is not legally binding.

Any correspondence mailed to You will be sent to Your most current address. You are responsible for notifying the Plan Administrator or the Claims Administrator of Your new address.

## YOUR RIGHT TO APPEAL

The Plan wants Your experience to be as positive as possible. There may be times, however, when You have a complaint, problem, or question about Your Plan or a service You have received. In those cases, please contact Member Services by calling the number on the back of Your Identification Card. The Claims Administrator will try to resolve Your complaint informally by talking to Your Provider or reviewing Your claim. If You are not satisfied with the resolution of Your complaint, You have the right to file an appeal, which is defined as follows:

For purposes of these appeal provisions, “claim for benefits” means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which You have not received the benefit or for which You may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which You have received the service.

If Your claim is denied or if Your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will follow will satisfy the requirements for a full and fair review under applicable Federal regulations.

### Notice of Adverse Benefit Determination

If Your claim is denied, the Claims Administrator’s notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the Claims Administrator’s determination is based;
- a description of any additional material or information needed to perfect Your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan’s review procedures and the time limits that apply to them, including a statement of Your right to bring a civil action under ERISA, if this Plan is subject to ERISA, within one year of the grievance or appeal decision if You submit a grievance or appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about Your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on Medical Necessity or experimental treatment, or about Your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- information regarding Your potential right to an External Appeal pursuant to Federal law.

For claims involving urgent/concurrent care:

- the Claims Administrator’s notice will also include a description of the applicable urgent/concurrent review process; and
- the Claims Administrator may notify You or Your authorized representative within 72 hours orally and then furnish a written notification.



## Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or Your authorized representative must file Your appeal within 180 calendar days after You are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting Your claim. The Claims Administrator's review of Your claim will take into account all information You submit, regardless of whether it was submitted or considered in the initial benefit determination.

- The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g., pre-service, concurrent, post-service, urgent, etc.).

**For pre-service claims involving urgent/concurrent care**, You may obtain an expedited appeal. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, You or Your authorized representative must contact the Claims Administrator at the number shown on Your Identification Card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g., Urgent Care). You or Your authorized representative must submit a request for review to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348

### **You must include Your Member Identification Number when submitting an appeal.**

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to Your diagnosis.

The Claims Administrator will also provide You, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with Your claim. In addition, before You receive an adverse benefit determination or review based on a new or additional rationale, the Claims Administrator will provide You, free of charge, with the rationale.

**For Out of State Appeals** You have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

### **How Your Appeal will be Decided**

When the Claims Administrator considers Your appeal, the Claims Administrator will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

### **Notification of the Outcome of the Appeal**

**If You appeal a claim involving urgent/concurrent care**, the Claims Administrator will notify You of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of Your request for appeal.

**If You appeal any other pre-service claim**, the Claims Administrator will notify You of the outcome of the appeal within 30 days after receipt of Your request for appeal.

**If You appeal a post-service claim**, the Claims Administrator will notify You of the outcome of the appeal within 60 days after receipt of Your request for appeal.

### **Appeal Denial**

If Your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Claims Administrator will include all of the information set forth in the above section entitled "Notice of Adverse Benefit Determination."

If, after the Plan's denial, the Claims Administrator considers, relies on or generates any new or additional evidence in connection with Your claim, the Claims Administrator will provide You with that new or additional evidence, free of charge. The Claims Administrator will not base its appeal decision on a new or additional rationale without first providing You (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If the Claims Administrator fails to follow the Appeal procedures outlined under this section the Appeals process may be deemed exhausted. However, the Appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond the Claims Administrator's control.

### **Voluntary Second Level Appeals**

If You are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If You would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

### **External Review**

If the outcome of the mandatory first level appeal is adverse to You and it was based on medical judgment, or if it pertained to a rescission of coverage, You may be eligible for an independent External Review pursuant to Federal law.

You must submit Your request for External Review to the Claims Administrator within four (4) months of the notice of Your final internal adverse determination.



A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that You submitted for internal appeal. However, You are encouraged to submit any additional information that You think is important for review.

For pre-service claims involving urgent/concurrent care, You may proceed with an expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Administrator's internal appeal process. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To proceed with an expedited External Review, You or Your authorized representative must contact the Claims Administrator at the number shown on Your Identification Card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by You or Your authorized representative to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348

**You must include Your Member identification number when submitting an appeal.**

This is not an additional step that You must take in order to fulfill Your appeal procedure obligations described above. Your decision to seek External Review will not affect Your rights to any other benefits under this health care plan. There is no charge for You to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA, if this Plan is subject to ERISA.

**Requirement to file an Appeal before filing a lawsuit**

No lawsuit or legal action of any kind related to a benefit decision may be filed by You in a court of law or in any other forum, unless it is commenced within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal appeals procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If Your health benefit plan is sponsored by Your Employer and subject to the Teammate Retirement Income Security Act of 1974 (ERISA) and Your appeal as described above results in an adverse benefit determination, You have a right to bring a civil action under Section 502(a) of ERISA within one year of appeal decision.

**The Claims Administrator reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.**

## COORDINATION OF BENEFITS (COB)

This Coordination of Benefits (COB) provision applies when You have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Benefit Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Benefit Booklet, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than the Plan's Maximum Allowed Amount.

### COB DEFINITIONS

**Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group and non group insurance contracts and subscriber contracts; Health Maintenance Organization (HMO) contracts; uninsured arrangements of group or group-type coverage; coverage under group or non group closed panel plans; group-type contracts; medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.
2. Plan does not include: Accident only coverage; specified disease or specified accident coverage; limited health benefit coverage; benefits for non-medical components of long term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; school accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

**This Plan** means the part of the contract providing health care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when You have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

**Allowable expense** is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering You. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering You is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If You are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If You are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If You are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because You have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
6. The amount that is subject to the Primary high-Deductible health plan's Deductible, if the Claims Administrator has been advised by You that all Plans covering You are high-Deductible health plans and You intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
7. Any amounts incurred or claims made under the Prescription Drug program of This Plan.

**Closed panel plan** is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

**Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

## ORDER OF BENEFIT DETERMINATION RULES

When You are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

1. Except as provided in Paragraph 2. below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

**Rule 1 - Non-Dependent or Dependent.** The Plan that covers You other than as a Dependent, for example as a Teammate, Member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers You as a Dependent is the Secondary Plan. However, if You are a Medicare beneficiary and, as a result of Federal law, Medicare is secondary to the Plan covering You as a Dependent and primary to the Plan covering You as other than a Dependent (e.g., a retired Teammate), then the order of benefits between the two Plans is reversed so that the Plan covering You as a Teammate, Member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering You as a Dependent is the Primary Plan.

**Rule 2 - Dependent Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
  - the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
  - if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
  - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
  - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
  - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
  - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    - the Plan covering the custodial parent;
    - the Plan covering the Spouse of the custodial parent;
    - the Plan covering the non-custodial parent; and then
    - the Plan covering the Spouse of the non-custodial parent.
3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of items 1 or 2 above will determine the order of benefits as if those individuals were the parents of the child.

4. For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouses plan, Rule 5 applies. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits will be determined by applying the birthday rule in item 1 above to the Dependent child's parent(s) and the Dependent's spouse.

**Rule 3 - Active Teammate or Retired or Laid-off Teammate.** The Plan that covers You as an active Teammate, that is, a Teammate who is neither laid off nor retired, is the Primary Plan. The Plan also covering You as a retired or laid-off Teammate is the Secondary Plan. The same would hold true if You are a Dependent of an active Teammate and You are a Dependent of a retired or laid-off Teammate. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

**Rule 4 - COBRA.** If You are covered under COBRA or under a right of continuation provided by other Federal law and are covered under another Plan, the Plan covering You as a Teammate, Member, subscriber or retiree or covering You as a Dependent of a Teammate, Member, subscriber or retiree is the Primary Plan and the COBRA or other Federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits. This rule does not apply when the person is covered either: (a) as a non- Dependent under both Plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as a Teammate or as a retired Teammate and is covered under his or her own Plan as a Teammate, Member, subscriber or retiree); or (b) as a Dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as a Dependent of a Teammate, Member or subscriber or retired Teammate and is covered under the other plan as a Dependent of a Teammate, Member, subscriber or retiree).

**Rule 5 - Longer or Shorter Length of Coverage.** The Plan that covered You longer is the Primary Plan and the Plan that covered You the shorter period of time is the Secondary Plan.

**Rule 6 -** If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

#### **EFFECT ON THE BENEFITS OF THIS PLAN**

When a Member is covered under two or more Plans which together pay more than this Plan's benefits, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Plan's benefit payments will not be affected when it is Primary. However, when this Plan is Secondary under the Order of Benefit Determination Rules, benefits payable by this Plan will be reduced by the combined benefits of all other Plans covering You or Your Dependent.

When the benefits of this Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan. If this Plan is secondary, the combined benefits of this Plan and the other Plan will never exceed what would have been provided by this Plan if primary. No benefits will be provided by this Plan when the amount paid by the other Plan is equal to or greater than the amount this Plan would have paid if Primary.

If You are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

## **RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Claims Administrator may get the facts it needs from, or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Claims Administrator any facts the Claims Administrator needs to apply those rules and determine benefits payable.

## **FACILITY OF PAYMENT**

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

## **RIGHT OF RECOVERY**

If the amount of the payments made by This Plan is more than should have paid under this COB provision, the Plan may recover the excess from one or more of the persons:

1. the Plan has paid or for whom the Plan have paid; or
2. any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## **When a Covered Person Qualifies for Medicare**

### **Determining Which Plan is Primary**

To the extent permitted by law, this Plan will pay Benefits second to Medicare when You become eligible for Medicare, even if You don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Subscribers with active current employment status age 65 or older and their Spouses age 65 or older, and
- individuals with end-stage renal disease, for a limited period of time.

### **Determining the Allowable Expense When This Plan is Secondary to Medicare**

If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the Provider accepts Medicare. If the Provider does not accept Medicare, the Medicare limiting charge (the most a Provider can charge You if they don't accept Medicare) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total Allowable Expense.

If You are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if You had been enrolled in Medicare.



## SUBROGATION AND REIMBURSEMENT

These provisions apply when the Plan pays benefits as a result of injuries or illnesses You sustained and You have a right to a Recovery or have received a Recovery from any source.

### Recovery

A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, workers' compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements characterize the money You receive as a Recovery, it shall be subject to these provisions.

### Subrogation

The Plan has the right to recover payments it makes on Your behalf from any party responsible for compensating You for Your illnesses or injuries. The following apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- You and Your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

### Reimbursement

If You obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on Your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on Your behalf and the following provisions will apply:

- You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to Your negligence.
- You and Your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (*i.e.*, the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon Your receipt of the Recovery. You and Your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset.
- Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.
- You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

- If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:
  1. The amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
  2. You fail to cooperate.
- In the event that You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate You or make You whole.

## Your Duties

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to You occurred, all information regarding the parties involved and any other information requested by the Plan.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by You to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.



## **GENERAL INFORMATION**

### **Entire Agreement**

This Benefit Booklet, the Administrative Services Agreement, the Employer's application, any Riders, Endorsements or attachments, and the individual applications of the Subscribers and Members, if any, constitute the entire agreement between the Claims Administrator and the Employer and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Claims Administrator by the Employer, and any and all statements made to the Employer by the Claims Administrator, are representations and not warranties, and no such statement unless it is contained in a written application for coverage under the Plan, shall be used in defense to a claim under the Plan.

### **Form or Content of Benefit Booklet**

No agent or Teammate of the Claims Administrator is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through an endorsement authorized and signed by an officer of the Employer.

### **Circumstances Beyond the Control of the Plan**

The Claims Administrator shall make a good-faith effort to arrange for an alternative method of administering benefits. In the event of circumstances not within the control of the Claims Administrator or Employer, including but not limited to: a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Claims Administrator, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided by the Plan is delayed or rendered impractical, the Claims Administrator shall make a good-faith effort to arrange for an alternative method of administering benefits. In such event, the Claims Administrator and Network Providers shall administer and render services under the Plan insofar as practical, and according to their best judgment; but the Claims Administrator and Network Providers shall incur no liability or obligation for delay, or failure to administer or arrange for services if such failure or delay is caused by such an event.

### **Protected Health Information Under HIPAA**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide You with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of Your information and details about a number of individual rights You have under the Privacy Regulations. As the Claims Administrator of Your Employer's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If You would like a copy of Anthem's Notice, contact the Member Services number on Your Identification Card.

### **Workers' Compensation**

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Workers' Compensation Law. All sums paid or payable by Workers' Compensation for services provided to a Member shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation or equivalent Employer liability or indemnification law.

### **Other Government Programs**

Except insofar as applicable law would require the Plan to be the primary payer, the benefits under the Plan shall not duplicate any benefits to which Members are entitled, or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

## **Medicare**

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to Federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and Federal law.

Except when Federal law required us to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to You shall be reimbursed by or on Your behalf to us, to the extent we have made payment for such services. If You do not enroll in Medicare Part B when You are eligible, You may have large out-of-pocket costs. Please refer to [Medicare.gov](http://Medicare.gov) for more details on when You should enroll, and when You are allowed to delay enrollment without penalties.

## **Right of Recovery and Adjustment**

Whenever payment has been made in error, the Plan will have the right to recover such payment from You or, if applicable, the Provider or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the plan year in which the error is discovered.

The Claims Administrator has oversight responsibility for compliance with Provider and vendor contracts. The Claims Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, The Claims Administrator has established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. The Claims Administrator will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount.

## **Relationship of Parties (Employer-Member-Claims Administrator)**

Neither the Employer nor any Member is the agent or representative of the Claims Administrator.

The Employer is fiduciary agent of the Member. The Claims Administrator's notice to the Employer will constitute effective notice to the Member. It is the Employer's duty to notify the Claims Administrator of eligibility data in a timely manner. The Claims Administrator is not responsible for payment of Covered Services of Members if the Employer fails to provide the Claims Administrator with timely notification of Member enrollments or terminations.

## **Relationship of Parties (Claims Administrator - Network Providers)**

The relationship between the Claims Administrator and Network Providers is an independent contractor relationship. Network Providers are not agents or Teammates of the Claims Administrator, nor is the Claims Administrator, or any Teammate of the Claims Administrator, a Teammate or agent of Network Providers.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Out-of-Network Providers, and disease management programs. If You have questions regarding such incentives or risk sharing relationships, please contact Your Provider or the Claims Administrator.

### **Anthem Health Plans of Virginia, Inc. Note**

The Employer, on behalf of itself and its Members, hereby expressly acknowledges its understanding that the Administrative Services Agreement (which includes this Benefit Booklet) constitutes a contract solely between the Employer and Anthem Health Plans of Virginia, Inc. (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Virginia. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield Plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of the Administrative Services Agreement or this Benefit Booklet.

### **Notice**

Any notice given under the Plan shall be in writing. The notices shall be sent to: The Employer at its principal place of business and/or to You at the Subscriber's address as it appears on the records or in care of the Employer.

### **Modifications or Changes in Coverage**

The Plan Sponsor may change the benefits described in this Benefit Booklet and the Member will be informed of such changes as required by law. This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer, or by mutual agreement between the Claims Administrator and the Employer without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

### **Fraud**

Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Member's coverage.

### **Acts Beyond Reasonable Control (Force Majeure)**

Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

The Claims Administrator will adhere to the Plan Sponsor's instructions and allow the Plan Sponsor to meet all of the Plan Sponsor's responsibilities under applicable state and Federal law. It is the Plan Sponsor's responsibility to adhere to all applicable state and Federal laws and the Claims Administrator does not assume any responsibility for compliance.

### **Conformity with Law**

Any provision of the Plan which is in conflict with the applicable Federal laws and regulations is hereby amended to conform with the minimum requirements of such laws.

### **Clerical Error**

Clerical error, whether of the Claims Administrator or the Employer, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue benefits otherwise validly terminated.

### **Policies and Procedures**

The Claims Administrator, on behalf of the Employer, may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which a Member shall comply.

Under the terms of the Administrative Service Agreement with Your Employer, the Claims Administrator has the authority, at its discretion, to institute from time to time, utilization management, care management, disease management or wellness pilot initiatives in certain designated geographic areas. These pilot initiatives are part of the Claims Administrator's ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of benefits which are not provided in the Employer's Group Health Plan, unless otherwise agreed to by the Employer. The Claim's Administrator reserves the right to discontinue a pilot initiative at any time without advance notice to the Employer.

### **Value-Added Programs**

The Claims Administrator may offer health or fitness related programs to Members, through which You may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under the Plan but are in addition to plan benefits. As such, program features are not guaranteed under Your Employer's Group health Plan and could be discontinued at any time. The Claims Administrator does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services You receive.

### **Waiver**

No agent or other person, except an authorized officer of the Employer, has authority to waive any conditions or restrictions of the Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

### **Employer's Sole Discretion**

The Employer may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Employer, with advice from the Claims Administrator, determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

### **Reservation of Discretionary Authority**

The Claims Administrator shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the Plan, to resolve Member appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. Anthem has complete discretion to interpret the Benefit Booklet. The Claims Administrator's determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowed Amount. A Member may utilize all applicable appeals procedures.

## **Governmental Health Care Programs**

Under Federal law, for groups with 20 or more Teammates, all active Teammates (regardless of age) can remain on the Group's Health Plan and receive group benefits as primary coverage. Also, Spouses (regardless of age) of active Teammates can remain on the Group's Health Plan and receive group benefits as primary coverage. Direct any questions about Medicare eligibility and enrollment to Your local Social Security Administration office.

## **Medical Policy and Technology Assessment**

The Claims Administrator reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/Investigational status or Medical Necessity of new technology. Guidance and external validation of the Claims Administrator's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Physicians from various medical specialties including the Claims Administrator's medical directors, Physicians in academic medicine and Physicians in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

## **Payment Innovation Programs**

The Claims Administrator pays Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by the Claims Administrator from time to time, but they will be generally designed to tie a certain portion of a Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, Network Providers may be required to make payment to the Claims Administrator under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect Your access to health care. The Program payments are not made as payment for specific Covered Services provided to You, but instead, are based on the Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by or to the Claims Administrator under the Program(s), and You do not share in any payments made by Network Providers to the Claims Administrator under the Program(s).

## **Care Coordination**

The Plan pays Network Providers in various ways to provide Covered Services to You. For example, sometimes the Plan may pay Network Providers a separate amount for each Covered Service they provide. The Plan may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, the Plan may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, the Plan may pay Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate Network Providers for coordination of Member care. In some instances, Network Providers may be required to make payment to the Plan because they did not meet certain standards. You do not share in any payments made by Network Providers to the Plan under these programs.

## **Program Incentives**

The Plan may offer incentives from time to time, at its discretion, in order to introduce You to covered programs and services available under this Plan. The purpose of these incentives include, but is not limited to, making You aware of cost effective benefit options or services, helping You achieve Your best health, and encouraging You to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as the Plan offers the incentives program. The Plan may discontinue an incentive for a particular covered program or service at any time. If You have any questions about whether receipt of an incentive or retailer coupon results in taxable income to You, it is recommended that You consult Your tax advisor.

## **Confidentiality and Release of Information**

Applicable state and Federal law requires us to undertake efforts to safeguard Your medical information.

For informational purposes only, please be advised that a statement describing our policies and procedures regarding the protection, use and disclosure of Your medical information is available on our website and can be furnished to You upon request by contacting our Member Services department.

Obligations that arise under state and Federal law and policies and procedures relating to privacy that are referenced but not included in this Benefit Booklet are not part of the contract between the parties and do not give rise to contractual obligations.



## WHEN COVERAGE TERMINATES

### Termination of Coverage (Individual)

Membership for You and Your enrolled family members may be continued as long as You are employed by the Employer and meet eligibility requirements. It ceases if Your employment ends, if You no longer meet eligibility requirements, if the Plan ceases, or if You fail to make any required contribution toward the cost of Your coverage. In any case, Your coverage would end at the expiration of the period covered by Your last contribution.

Coverage of an enrolled child ceases at the end of the month when the child attains the age limit shown in the **Eligibility** section. Coverage of an impaired child over age 26 ceases if the child is found to be no longer totally or permanently impaired.

Coverage of the Spouse of a Subscriber terminates at the end of the month as of the date of divorce or death.

### Continuation of Coverage (Federal Law-COBRA)

If Your coverage ends under the Plan, You may be entitled to elect continuation coverage in accordance with Federal law. If Your Employer normally employs 20 or more people, and Your employment is terminated for any reason other than gross misconduct You may elect from 18-36 months of continuation benefits. You should contact Your Employer if You have any questions about Your COBRA rights.

### Qualifying Events for Continuation Coverage Under Federal Law (COBRA)

COBRA continuation coverage is available when Your group coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, Your Spouse and Your Dependent children could become qualified beneficiaries if covered on the day before the qualifying event and group coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each member of Your family who is enrolled in the company's Teammate welfare benefit plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their Spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.



Qualifying Event	Length of Availability of Coverage
<b><u>For Teammates:</u></b> Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked	18 months
<b><u>For Spouses/ Dependents:</u></b> A Covered Teammate's Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked  Covered Teammate's Entitlement to Medicare  Divorce or Legal Separation  Death of a Covered Teammate	18 months   36 months  36 months  36 months
<b><u>For Dependents:</u></b> Loss of Dependent Child Status	36 months

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if You become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for Your Spouse and children can last up to 36 months after the date of Medicare entitlement.)

If You are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your Employer, and that bankruptcy results in the loss of coverage, You will become a qualified beneficiary with respect to the bankruptcy. Your surviving Spouse and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life. His or her Spouse and Dependents may continue coverage for a maximum period of up to 36 months following the date of the retiree's death.

### **Second Qualifying Event**

If Your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, Your Spouse and Dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused Your Spouse or Dependent children to lose coverage under the Plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

### **Notification Requirements**

In the event of Your termination, lay-off, reduction in work hours or Medicare entitlement, Your Employer must notify the company's benefit Plan Administrator within 30 days. You must notify the company's benefit Plan Administrator within 60 days of Your divorce, legal separation or the failure of Your enrolled

Dependents to meet the program's definition of Dependent. This notice must be provided in writing to the Plan Administrator. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

To continue enrollment, You or an eligible family member must make an election within 60 days of the date Your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies You or Your family member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage You choose to continue. If the Premium rate changes for active associates, Your monthly Premium will also change. The Premium You must pay cannot be more than 102% of the Premium charged for Teammates with similar coverage, and it must be paid to the company's benefit Plan Administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or Your continuation rights will be forfeited.

For Teammates who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Teammates who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Teammates' Dependents are also eligible for the 18 to 29-month disability extension. (This provision also applies if any covered family member is found to be disabled.) This provision would only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

#### **Trade Adjustment Act Eligible Individual**

If You don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused You to be eligible initially for COBRA coverage under this Plan, You will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which You become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period.

#### **When COBRA Coverage Ends**

These benefits are available without proof of insurability and coverage will end on the earliest of the following:

- a covered individual reaches the end of the maximum coverage period;
- a covered individual fails to pay a required Premium on time;
- a covered individual becomes covered under any other group health plan after electing COBRA;
- a covered individual becomes entitled to Medicare after electing COBRA; or
- the group terminates all of its group welfare benefit plans.

#### **Other Coverage Options Besides COBRA Continuation Coverage**

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

#### **If You Have Questions**

Questions concerning Your Group's health Plan and Your COBRA continuation coverage rights should be addressed to the Employer. For more information about Your rights under ERISA, if this Plan is subject to ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department

of Labor's Teammate Benefits Security Administration (EBSA) in Your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

### **Continuation of Coverage During Military Leave (USERRA)**

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Member may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Teammate (or his or her Dependents) is covered under this Plan, and if the Teammate becomes absent from employment by reason of military leave, the Teammate (or his or her Dependents) may have the right to elect to continue health coverage under the Plan. In order to be eligible for coverage during the period that the Teammate is gone on military leave, the Teammate must give reasonable notice to the Employer of his or her military leave and the Teammate will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Teammate and his or her Dependents can elect to continue coverage under the plan for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Teammate to apply for or return to work with the Employer. During military leave the Teammate is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Teammate's absence is less than 31 days, the Employer must continue to pay its portion of the premiums and the Teammate is only required to pay his or her share of the premiums without the COBRA-type 2% administrative surcharge.

Also, when the Teammate returns to work, if the Teammate meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Teammate did not elect COBRA continuation. These requirements are (i) the Teammate gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Teammate must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Teammate must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The Teammate may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Teammate upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Teammate's reinstatement of coverage.

### **Continuation of Coverage Due to Family and Medical Leave (FMLA)**

A Teammate may continue membership in the Plan as provided by the Family and Medical Leave Act. A Teammate who has been employed at least one year, within the previous 12 months is eligible to choose to continue coverage for up to 12 weeks of unpaid leave for the following reasons:

- the birth of the Teammate's child;
- the placement of a child with the Teammate for the purpose of adoption or foster care;
- to care for a seriously ill Spouse, child or parent; or,
- a serious health condition rendering the Teammate unable to perform his or her job.

If the Teammate chooses to continue coverage during the leave, the Teammate will be given the same health care benefits that would have been provided if the Teammate were working, with the same premium contribution ratio. If the Teammate's premium for continued membership in the Plan is more than 30 days late, the Employer will send written notice to the Teammate. It will tell the Teammate that his or her membership will be terminated and what the date of the termination will be if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

If membership in the Plan is discontinued for non-payment of premium, the Teammate's coverage will be restored to the same level of benefits as those the Teammate would have had if the leave had not been taken and the premium payment(s) had not been missed. This includes coverage for eligible Dependents.

The Teammate will not be required to meet any qualification requirements imposed by the Plan when he or she returns to work. This includes: new or additional waiting periods; waiting for an open enrollment period; or passing a medical exam to reinstate coverage.

Please contact Your Human Resources Department for state specific Family and Medical Leave Act information.

## For More Information

This notice does not fully describe the continuation coverage or other rights under the Plan. More information about continuation coverage and Your rights under this Plan is available from the Plan Administrator.

If You have any questions concerning the information in this notice or Your rights to coverage, You should contact Your Employer.

For more information about Your rights under ERISA, if this Plan is subject to ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S Department of Labor's Teammate Benefits Security Administration (EBSA) in Your area, or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

## DEFINITIONS

### **Accidental Injury**

Bodily Injury sustained by a Member as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Member receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, Employer's liability or similar law.

### **Administrative Services Agreement**

The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health Plan. This Benefit Booklet in conjunction with the Administrative Services Agreement, the application, if any, any amendment or rider, Your Identification Card and Your application for enrollment constitutes the entire Plan. If there is any conflict between either this Benefit Booklet or the Administrative Services Agreement and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Benefit Booklet and the Administrative Services Agreement, the Administrative Services Agreement shall control.

### **Ambulance Services**

A state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

### **Authorized Service(s)**

A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Claims Administrator to be paid at the Network level. The Member **may** be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any applicable Network Coinsurance, Copayment or Deductible. For more information, see the **Claims Payment** section.

### **Behavioral Health Care**

Includes services for Mental Health and Substance Abuse. Mental Health and Substance Abuse is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

### **Biosimilar/Biosimilars**

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product.

### **Brand Name Drug**

The initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met any manufacturer can produce the drug and sell under its own brand name, or under the drug's chemical name (Generic).

### **Centers of Excellence (COE) Network**

A network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein Members access select types of benefits through a specific network of medical centers.

A network of health care professionals contracted with the Claims Administrator or one or more of its affiliates, to provide transplant or other designated specialty services.

### Claims Administrator

The company the Plan Sponsor chose to administer its health benefits. Anthem Health Plans of Virginia, Inc. was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

### Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after You meet your Deductible. For example, if Your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is \$100, Your Coinsurance would be \$20 after You meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the **Schedule of Benefits** for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments (except as described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section).

### Combined Limit

The maximum total of Network and Out-of-Network benefits available for designated health services in the **Schedule of Benefits**.

### Complications of Pregnancy

Complications of Pregnancy result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a Complication of Pregnancy.

Complications of Pregnancy shall not include false labor, caesarean section, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

### Congenital Anomaly

A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

### Controlled Substances

Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) which are divided into five schedules.

### Coordination of Benefits

A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

### Copayment

A cost-sharing arrangement in which a Member pays a specified charge for a Covered Service, such as the Copayment indicated in the **Schedule of Benefits** for an office visit. The Member is usually responsible for payment of the Copayment at the time the health care is rendered. Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services



rendered and are typically collected by the Provider when services are rendered. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the Maximum Allowed Amount.

### **Cosmetic Surgery**

Any non-Medically Necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to: rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

### **Covered Dependent**

Any Dependent in a Subscriber's family who meets all the requirements of the **Eligibility** section of this Benefit Booklet, has enrolled in the Plan, and is subject to administrative service fee requirements set forth by the Plan.

### **Covered Services**

Medically Necessary health care services and supplies that are: (a) defined as Covered Services in the Member's Plan, (b) not excluded under such Plan, (c) not Experimental/Investigative and (d) provided in accordance with such Plan.

### **Covered Transplant Procedure**

Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the Claims Administrator including necessary acquisition procedures, collection and storage, and including Medically Necessary preparatory myeloablative therapy.

### **Custodial Care**

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

### **Deductible**

The portion of the bill You must pay before Your medical expenses become Covered Services. It usually is applied on a plan year basis.

### **Dependent**

The Spouse and all children until attaining age limit stated in the **Eligibility** section. Children include natural children, legally adopted children, foster children that live with the Teammate and for whom the Teammate is the primary source of financial support, and stepchildren. Also included are Your children (or children of Your Spouse) for whom You have legal responsibility resulting from a valid court decree.



Mentally, intellectually or physically disabled children remain covered no matter what age. You must give the Claims Administrator evidence of Your child's incapacity within 31 days of attainment of age 26. The

certification form may be obtained from the Claims Administrator or Your Employer. This proof of incapacity may be required annually by the Plan. Such children are not eligible under this Plan if they are already 26 or older at the time coverage is effective.

### **Designated Pharmacy Provider**

A Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with the Claims Administrator or a Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

### **Detoxification**

The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

### **Developmental Delay**

The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury.

### **Durable Medical Equipment**

Equipment which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease or Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have a disease or Injury; (e) not for exercise or training.

### **Effective Date**

The date for which the Plan approves an individual application for coverage. For individuals who join this Plan after the first enrollment period, the Effective Date is the date the Claims Administrator approves each future Member according to its normal procedures.

### **Elective Surgical Procedure**

A surgical procedure that is not considered to be an emergency, and may be delayed by the Member to a later point in time.

### **Emergency Medical Condition**

("Emergency services," "emergency care," or "Medical Emergency") Emergency Medical Condition means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

### **Employer**

An Employer who has allowed its Teammates to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides.

## Experimental/Investigative

Any Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, Injury, illness, or other health condition which the Claims Administrator determines to be unproven.

The Claims Administrator will deem any Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Claims Administrator, determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Claims Administrator. In determining whether a service is Experimental/Investigative, the Claims Administrator will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Claims Administrator to determine whether a Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

- documents issued by and/or filed with the FDA or other Federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

The Claims Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

### **Formulary**

A document setting forth certain rules relating to the coverage of pharmaceuticals, that may include but not be limited to (1) a listing of preferred Prescription medications that are covered and/or prioritized in order of preference by the Claims Administrator, and are dispensed to Members through pharmacies that are Network Providers, and (2) Precertification rules. This list is subject to periodic review and modification. Charges for medications may be Ineligible Charges, in whole or in part, if a Member selects a medication not included in the Formulary.

### **Freestanding Ambulatory Facility**

A facility, with a staff of Physicians, at which surgical procedures are performed on an outpatient basis (no patients stay overnight). The facility offers continuous service by both Physicians and registered nurses (R.N.s). It must be licensed and accredited by the appropriate agency. A Physician's office does not qualify as a Freestanding Ambulatory Facility.

### **Generic Drugs**

Drugs which have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark. A drug whose active ingredients duplicates those of a Brand Name Drug and is its bioequivalent, Generic Drugs must meet the same FDA specifications for safety, purity and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name Drug. On average, Generic Drugs cost about half as much as the counterpart Brand Name Drug.

### **Group Health Plan or Plan**

A Teammate welfare benefit plan (as defined in Section 3(1) of ERISA), established by the Employer, in effect as of the Effective Date.

### **Home Delivery(Mail Service)**

A Prescription Drug program which offers a convenient means of obtaining maintenance medications by mail if the Member takes Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Home Delivery (Mail Service), which has entered into a reimbursement agreement with the Claims Administrator and sent directly to the Member's home.

### **Home Health Care**

Care, by a licensed program or Provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

### **Home Health Care Agency**

A Provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed and accredited by the appropriate agency.

### **Hospice**

A Provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed and accredited by the appropriate agency.

### **Hospice Care Program**

A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Member and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed and accredited by the appropriate agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

### **Hospital**

An institution licensed and accredited by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- an extended care facility; nursing home; place for rest; facility for care of the aged;
- a custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- an institution for exceptional or disabled children.

### **Identification Card**

The latest card given to You showing Your identification and group numbers, the type of coverage You have and the date coverage became effective.

### **Ineligible Charges**

Charges for health care services that are not Covered Services because the services are not Medically Necessary or Precertification was not obtained. Such charges are not eligible for payment.

### **Ineligible Provider**

A Provider which does not meet the minimum requirements to become a contracted Provider with the Claims Administrator. Services rendered to a Member by such a Provider are not eligible for payment.

### **Infertile or Infertility**

The condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

### **Initial Enrollee**

A person actively employed by the Employer (or one of that person's Covered Dependents) who was either previously enrolled under the group coverage which this Plan replaces or who is eligible to enroll on the Effective Date of this Plan.

### **Injury**

Bodily harm from a non-occupational accident.

### **Inpatient**

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

### **Intensive Care Unit**

A special unit of a Hospital that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

### **Intensive Outpatient Programs**

Short-term behavioral health treatment that provides a combination of individual, group and family therapy.

### **Interchangeable Biologic Product**

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, is expected to produce the same clinical result as the reference product in any given patient.

### **Late Enrollees**

Late Enrollees mean Teammates or Dependents who request enrollment in a health benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/her initial enrollment period under the Plan; (b) the person enrolls during a special enrollment period; or (c) a court orders that coverage be provided for a minor Covered Dependent under a Member's Plan, but only as long as the Member requests enrollment for such Dependent within thirty-one (31) days after the court order is so issued. Late Enrollees are those who declined coverage during the initial open enrollment period and did not submit a certification to the Plan that coverage was declined because other coverage existed.

### **Maintenance Pharmacy**

A Network Retail Pharmacy that is contracted with the PBM to dispense a 90 day supply of Maintenance Medication.

### **Maternity Care**

Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit and the newborn infant is an eligible Member under the Plan.

## Maximum Allowed Amount

The maximum amount that the Plan will allow for Covered Services You receive. For more information, see the **Claims Payment** section.

## Medical Facility

A facility, including but not limited to, a Hospital, Freestanding Ambulatory Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Benefit Booklet. The facility must be licensed, accredited, registered or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Claims Administrator.

## Medical Necessity or Medically Necessary

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or Injury and that is determined by the Claims Administrator to be:

- medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or Injury;
- obtained from a Provider;
- provided in accordance with applicable medical and/or professional standards;
- known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- the most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, Injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;
- not Experimental/Investigative;
- not primarily for the convenience of the Member, the Member's family or the Provider; or,
- not otherwise subject to an exclusion under this Benefit Booklet.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and **does not** guarantee payment.

## Member

Individuals, including the Subscriber and his/her Dependents, who have satisfied the Plan eligibility requirements of the Employer, applied for coverage, and been enrolled for Plan benefits.

## Network Provider

A Physician, health professional, Hospital, Pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide Covered Services to Members through negotiated reimbursement arrangements. A Network Provider for one plan may not be a Network Provider for another. Please see "How to Find a Provider in the Network" in the section **How Your Plan Works** for more information on how to find a Network Provider for this Plan.

## New Hire

A person who is not employed by the Employer on the original Effective Date of the Plan.



### **Non-Covered Services**

Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

### **Out-of-Network Provider**

A Provider, including but not limited to, a Hospital, Freestanding Ambulatory Facility (Surgical Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies, that does not have an agreement or contract with the Claims Administrator to provide services to its Members at the time services are rendered.

Benefit payments and other provisions of this Plan are limited when a Member uses the services of Out-of-Network Providers.

### **Out-of-Pocket Maximum**

The maximum amount of a Member's Coinsurance payments during a given Plan year. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the Maximum Allowed Amount for Covered Services.

### **Partial Hospitalization Program**

Structured, short-term behavioral health treatment that offers nursing care and active treatment in a program that operates no less than 6 hours per day, 5 days per week.

### **Pharmacy**

An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or an Out-of-Network Provider.

### **Physical Therapy**

The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care.

### **Physician**

Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (PhD) are also Providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

### **Plan**

The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's health benefits.

### **Plan Administrator**

The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. **The Plan Administrator is not the Claims Administrator.**

### **Plan Sponsor**

The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. **The Plan Sponsor is not the Claims Administrator.**

### **Plan Year**

The period of time beginning at 12:00 A.M. on June 1<sup>st</sup>, continuing through the following January, and ending on May 31<sup>st</sup> at 11:59 P.M. It does not begin before a Member's Effective Date. It does not continue after a Member's coverage ends.

### **Prescription Drug (Drug) (Also referred to as Legend Drug)**

A medicine that is approved by the Food & Drug Administration (FDA) to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- Compounded (combination) medications, when all of the ingredients are FDA-approved, as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a Prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
- Insulin.

### **Prescription Order or Prescription**

A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

### **Primary Care Physician**

A Provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

### **Prior Authorization**

The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

### **Provider**

A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers that deliver Covered Services are described throughout this Benefit Booklet. If You have a question if a Provider is covered, please call the number on the back of Your Identification Card.

### **QMCSO, or MCSO – Qualified Medical Child Support Order or Medical Child Support Order**

A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit plan to receive benefits for which the Teammate is entitled under the plan; and includes the name and last known address of the Teammate and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies.

An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- provides for child support payment related to health benefits with respect to the child of a group health plan Member or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- enforces a state law relating to medical child support payment with respect to a group health plan.

### **Residential Treatment Center / Facility**

A Provider licensed and operated as required by law, which includes:

- Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability;
- A staff with one or more Doctors available at all times.
- Residential treatment takes place in a structured Facility-based setting.
- The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
- Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
- Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

### **Retail Health Clinic**

A facility that provides limited basic medical care services to Members on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

### **Semiprivate Room**

A Hospital room which contains two or more beds.

### **Skilled Convalescent Care**

Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient’s home or in a nursing home not certified as a Skilled Nursing Facility.

### **Skilled Nursing Facility**

An institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the by the Claims Administrator.

### **Specialist (Specialty Care Physician\Provider or SCP)**

A Specialist is a doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

## Specialty Drugs

Typically high cost drugs that are injected or infused in the treatment of acute or chronic diseases. Specialty Drugs often require special handling such as temperature-controlled packaging and expedited delivery. Most Specialty Drugs require preauthorization to be considered Medically Necessary.

## Spouse

For the purpose of this Plan, a Spouse is defined as shown in the **Eligibility** section of this Benefit Booklet.

## Teammate

A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the employment regulations of the Employer. The Teammate is also called the Subscriber.

## Therapeutic Equivalent

Therapeutic/Clinically Equivalent drugs are drugs that can be expected to produce similar therapeutic outcomes for a disease or condition.

## Transplant Providers

**Network Transplant Provider** - A Provider that has been designated as a "Center of Excellence" for Transplants by the Claims Administrator and/or a Provider selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Such Provider has entered into a transplant Provider agreement to render Covered Transplant Procedures and certain administrative functions to You for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- certain Covered Transplant Procedures; or
- all Covered Transplant Procedures.

**Out-of-Network Transplant Provider** - Any Provider that has NOT been designated as a "Center of Excellence" for Transplants by the Claims Administrator nor has not been selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association.

## Urgent Care

Services received for a sudden, serious, or unexpected illness, Injury or condition. Urgent Care is not considered an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening.

## Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures, and/or facilities.

## You and Your

Refer to the Subscriber, Member and each Covered Dependent.

## HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

### Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in the Claims Administrator's Network and who is available to accept You or Your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of Your Identification Card or refer to the Claims Administrator's website, [www.anthem.com](http://www.anthem.com). For children, You may designate a pediatrician as the PCP.

### Access to Obstetrical and Gynecological (ObGyn) Care

You do not need Prior Authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services or following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of Your Identification Card or refer to the Claims Administrator's website, [www.anthem.com](http://www.anthem.com).

### Statement of Rights Under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider (e.g., Your Physician, nurse midwife, or Physician assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce Your Out-of-Pocket costs, You may be required to obtain Precertification. For information on Precertification, contact Your Plan Administrator.

Also, under Federal law, plans may not set the level of benefits or Out-of-Pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

### Statement of Rights Under the Women's Cancer Rights Act of 1998

If You have had or are going to have a mastectomy, You may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. See the **Schedule of Benefits**.

If You would like more information on WHCRA benefits, call Your Plan Administrator.

### **Coverage for a Child Due to a Qualified Medical Support Order (“QMCSO”)**

If You or Your Spouse are required, due to a QMCSO, to provide coverage for Your child(ren), You may ask Your Employer or Plan Administrator to provide You, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

### **Mental Health Parity and Addiction Equity Act**

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day/visit limits on medical/surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day/visit limits for medical and surgical benefits. A plan that does not impose day/visit limits on medical and surgical benefits may not impose such day/visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment/Coinsurance and out-of-pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment/Coinsurance and out-of-pocket expenses applicable to other medical and surgical benefits. Medical Necessity criteria are available upon request.

### **Special Enrollment Notice**

If You are declining enrollment for yourself or Your Dependents (including Your Spouse) because of other health insurance coverage, You may in the future be able to enroll yourself or Your Dependents in this Plan, if You or Your Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards You or Your Dependents' other coverage). However, You must request enrollment within 31 days after You or Your Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if You have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, You may be able to enroll yourself and Your Dependents. However, You must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Teammates and Dependents may also enroll under two additional circumstances:

- the Teammate's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Teammate or Dependent becomes eligible for a subsidy (state premium assistance program)

The Teammate or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call the Member Services telephone number on Your Identification Card or contact Your Plan Administrator.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross and Blue Shield of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Company (WCIC). CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.



## IT'S IMPORTANT WE TREAT YOU FAIRLY

That's why we follow Federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on Your Identification Card for help (TTY/TDD: 711). If You think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, You can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or You can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## GET HELP IN YOUR LANGUAGE

Curious to know what all this says? We would be too. Here's the English version:

You have the right to get this information and help in Your language for free. Call the Member Services number on Your Identification Card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for Members with visual impairments. If You need a copy of this document in an alternate format, please call the Member Services telephone number on the back of Your Identification Card.

## Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

## Albanian

Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

## Amharic

000000 0000 00 0000 000000 0000 0000 000000 0000 000000 000000 00000000 00 0000  
00000 00000000 0000 000000 (TTY/TDD: 711)

## Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (TTY/TDD: 711)

## Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

## Bassa

M bédé dyí-bèdèin-dèò bé m ké bǎ nià ke kè gbo-kpá- kpá dyé qé m bídí-wùdùün bó pídyi. Éa mébà jè gbo-gmò Kpòè nòbà nià ni Dyí-dyoìn-běǎ kǎe bé m ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

## Bengali

(TTY/TDD: 711)

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## Burmese

ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရပိုင်ခွင့် သင့်တွင်ရှိပါသည်။  
အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။  
(TTY/TDD: 711)

## Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

## Dinka

Yin non yic ba ye lëk ně yök ku bë yi kuony ně thöŋ yin jăm ke cın wëu töu kě piiny. Cöl răn tōŋ dẽ kóc kě luoi ně nămba dẽn tō ně l.D kat du yic. (TTY/TDD: 711)

## Dutch

U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstnummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

## Farsi

شما این حق را دارید که این اطلاعات و کمک‌ها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات (711/TTY/TDD) اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید.

## French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

## German

Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

## Greek

Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (Identification Card) για βοήθεια. (TTY/TDD: 711)

## Gujarati

711) \_\_\_\_\_ (TTY/TDD: \_\_\_\_\_)

## Haitian

Ou gen dwa pou resewa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

## Hindi

0000 0000 00 00000000 00 0000 0000 00000000 00000000 0000 00  
 000000 000 000 00 0000 0000 ID 000000 00 000000 000000 0000 00 0000 000000  
 (TTY/TDD: 711)

## Hmong

Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

## Igbo

I nwere ikike inweta ozi a yana enyemaka n'asụsụ gi n'efu. Kpọọ nomba Ọrụ Onye Otu di na kaadi NJ gi maka enyemaka. (TTY/TDD: 711)

# Ilokano

Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

## Indonesian

Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)



Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)





# EXHIBIT C

**AMENDMENT 2 TO THE  
ADMINISTRATIVE SERVICES AGREEMENT  
WITH  
OWENS & MINOR, INC. "EMPLOYER"**

This Amendment is made part of the Administrative Services Agreement and is effective January 1, 2020. This Amendment supplements and amends the Agreement between Employer and HealthKeepers, Inc. and Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield. If there are any inconsistencies between the terms of the Agreement or its Schedules and this Amendment, the terms of this Amendment shall control.

1. **"ARTICLE 1 - DEFINITIONS Prescription drug" is intentionally omitted in its entirety.**
2. **"ARTICLE 1 - DEFINITIONS Prescription Drug Claims" is intentionally omitted in its entirety.**
3. **The following provision replaces Article 2 - Administrative Services Provided by Anthem (e) in its entirety:**
  - e) Anthem shall perform Claims prepayment analysis and recovery services as provided in Articles 4 and 13.
4. **Article 2 - Administrative Services Provided by Anthem provision (v) is intentionally omitted in its entirety.**
5. **The following provision is added to Article 2 - Administrative Services Provided by Anthem as provision (z):**
  - z) Anthem generally receives Member telephone numbers from Employer through enrollment files or the online employer access portal. Telephone numbers are provided directly to Employer by Members with the understanding that Anthem may contact them, and Employer does not obtain telephone numbers through a service or a third party. Anthem may contact Members by telephone for clinical purposes, benefit related issues or to perform services under the Agreement. Telephone numbers may be updated periodically by Members, and Anthem will honor do not call requests. With regard to Anthem's use of Member telephone numbers, Employer agrees to retain Member enrollment records for a period of at least 4 years or as otherwise set forth in the Telephone Consumer Protection Act and, upon request, will provide such records to Anthem in a timely manner.
6. **The following provision is added to Article 4 - Claims Payment Method as provision (c):**
  - c) Employer acknowledges and directs Anthem to utilize offsetting and cross-plan offsetting to recover overpaid Claims from Network Providers. Offsetting and cross-plan offsetting will be conducted only in cooperation with non-Network Providers who have expressly agreed to such procedures and have agreed that members will be held harmless. Offsetting is the practice of Anthem recovering overpayments made to a Network Provider by withholding overpaid amounts from subsequent payments to be made to the same Network Provider. Cross-plan offsetting is the practice of Anthem recovering overpayments made to a Network Provider for one member by withholding the overpaid amount from subsequent payments to be made to the same Network Provider for another member, who receives benefits under a different group health plan for which Anthem pays the Claims on behalf of a different employer.
7. **The following provision replaces Article 13 - Recovery and PrePayment Analysis Services (b) in its entirety:**
  - b) Anthem may become aware of additional recovery opportunities by means other than those described in Article 13(a). Employer grants Anthem the authority and discretion in those instances to do the following: (1) determine and take steps reasonably necessary and cost-effective to pursue the recovery such as filing a proof of claim in a class action settlement, adjusting Claims by offsetting or cross-plan offsetting as described in Article 4, commencing litigation, opting out of or objecting to a proposed settlement, and/or engaging in settlement negotiations; (2) select and retain outside counsel when needed; (3) reduce any recovery obtained on behalf of the Plan by its proportionate share of the outside counsel fees and costs incurred during litigation or settlement activities to obtain

such recovery; and (4) implement or effect any settlement of the Employer's and Plan's rights by, among other things, executing a release waiving the Employer's and Plan's rights to take any action inconsistent with the settlement.

8. **Article 14 - Pharmacy Benefits and Services is intentionally omitted in its entirety:**
9. **Schedule A is replaced by the attached Schedule A.**
10. **Schedule B is replaced by the attached Schedule B.**
11. **Schedule C is replaced by the attached Schedule C.**
12. **Pharmacy Benefits Administrative Services Schedule is added as attached.**
13. **Exhibit A - Fees & Expenses of The Pharmacy Benefits Administrative Services Schedule is added as attached.**
14. **Exhibit B - Pharmacy Services of The Pharmacy Benefits Administrative Services Schedule is added as attached.**
15. **Exhibit C - Performance Guarantees of The Pharmacy Benefits Administrative Services Schedule is added as attached.**

IN WITNESS WHEREOF, Anthem has caused this Amendment to be executed by affixing the signature of its duly authorized officer.

HealthKeepers, Inc. and Anthem Health Plans of  
Virginia, Inc. dba Anthem Blue Cross and Blue Shield



By: John Hogan  
Title: RVP Underwriting II  
Date: March 30, 2020

**SCHEDULE A  
TO  
ADMINISTRATIVE SERVICES AGREEMENT  
WITH  
OWENS & MINOR, INC.**

This Schedule A shall govern the Agreement Period from January 1, 2020 through December 31, 2020. For purposes of this Agreement Period, this Schedule shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules, and this Schedule A, the terms of this Schedule A shall control.

**Section 1. Effective Date and Renewal Notice**

This Agreement Period shall be from 12:01 a.m. January 1, 2020 to the end of the day of December 31, 2020.

Paid Claims shall be processed pursuant to the terms of this Agreement when incurred and paid as follows:

Incurred from June 1, 2017 through December 31, 2020 and  
Paid from January 1, 2020 through December 31, 2020.

Anthem shall provide any offer to renew this Agreement at least 90 days prior to the end of an Agreement Period.

**Section 2. Broker or Consultant Base Compensation**

The Mercer Oversight Fee is \$2.46 per Subscriber per month for Subscribers in the MHA Model. The Mercer Oversight Fee is not included in the Administrative Services Fees described in Section 3 of this Schedule A. Upon receipt of payment from Employer, Anthem shall remit payment to Mercer

**Section 3. Administrative Services Fees**

Change to Administrative Services Fees. In addition to the provisions in Article 18(c), Anthem reserves the right to change the Administrative Services Fees provided in this Section 3 of Schedule A during the Agreement Period based upon the occurrence of any of the following events:

- Employer's Member to Subscriber ratio is not within +/-5% of 1.93;
- Anthem is not the sole third party administrator for medical benefits under Employer's Plan;
- Employer's enrollment is not within +/-10% of 5,018 Subscribers;
- A change in law or regulation that materially impacts underwriting assumptions made at the time of the offer or renewal.

If Employer terminates the Pharmacy Services Schedule with PBM at any time, then Anthem shall have the right to amend the Administrative Services Fees indicated in Section 3 of Schedule A of this Agreement.

**A. Base Administrative Services Fee**

Base Administrative Services Fee:	\$36.20 per Subscriber per month
Less Volume Discount:	\$ 0.00 per Subscriber per month
Discounted Administrative Services Fee:	\$36.20 per Subscriber per month

**Article 3(a) Retroactive Adjustments to Enrollment.**

Anthem shall credit Administrative Services Fees for each retroactive deletion up to a maximum of 60 days and shall charge Administrative Services Fees for each retroactive addition up to a maximum of 60 days.

**B. Health and Wellness Program Fees**

Mercer Health Advantage - Mercer Health Advantage (MHA) is a primary nurse integrated health model with a designated member services arrangement and access to pricing arrangements and Performance Guarantees offered for purchase from Anthem, with oversight from Mercer.

Base Admin Fee:	\$ 36.20 per Subscriber per month
Mercer Health Advantage Fee:	\$ 11.16 per Subscriber per month
Less Volume Discount:	\$ 0.22 per Subscriber per month
Discounted Mercer Health Advantage Fee:	\$ 47.14 per Subscriber per month

Integrated Imaging Package: \$1.39 per Subscriber per month

**C. Other Fees or Credits**

Fee for Subrogation Services. The charge to Employer is 25% of gross subrogation recovery.

Fee for Overpayment Identification and Claims Prepayment Analysis Activities. The charge to Employer is 25% of (i) the amount recovered from review of Claims and membership data and audits of Provider and Vendor activity to identify overpayments and (ii) the difference between the amount Employer would have been charged absent prepayment analysis activities and the amount that was charged to Employer following performance of the prepayment analysis activities. This includes, but is not limited to COB, contract compliance, and eligibility. The fee for Overpayment Identification and Claims Prepayment Analysis Activities will not exceed \$25,000 per Claim.

Fee for Independent Claims Review: \$550.00 per independent review

Non-Network Savings Fee. If Anthem or its Vendor negotiates with a non-Network Provider for Covered Services from the non-Network Provider, [Employer] will pay a fee equal to 50% of the difference between the non-Network Provider's Billed Charges and the amount Anthem uses to calculate Plan liability for the Covered Service (the "Plan Liability Amount"). In the case of facility-based Provider Claims, Plan Liability Amount will be based on the negotiated rate; if negotiations are not successful, the Plan Liability Amount shall be determined using a pricing tool. In the case of professional Provider Claims, Plan Liability Amount will be based upon the negotiated rate obtained by Anthem or its Vendor, if applicable (in the absence of successfully negotiated Claims, there will be no fee charged as the amount will be determined by the local Blue plan). These Claims will not be included in any Performance Guarantee calculations.

Third Party Stop Loss Reporting Fee: Employer will pay a fee of \$1.25 per Subscriber per month for generation of reports delivered to an external stop loss carrier. Confidentiality Agreements must be completed with the Employer and third party stop loss carrier prior to files being released.

Fee for Ad Hoc Reports. Anthem shall provide, on an annual basis, up to 20 hours of time needed to generate custom or ad hoc reports at no additional charge. The charge to Employer beyond 20 hours per year is \$150.00 per hour for time needed to generate custom or ad hoc reports.

Fee for Electronic Data Feeds to an Outside Vendor. Anthem shall provide, on an annual basis, up to 12 electronic data feeds to an outside vendor in Anthem's standard format. The charge to Employer is \$1,000.00 for each additional feed.

Private Exchange Services Fee \$15.66 per Subscriber per month

Employee Assistance Program (EAP): \$1.12 per eligible Employee per month

Fee for Non-Standard Payment Terms for Paid Claims. Under Anthem's standard payment terms, the Invoice Due Date as specified in the invoice is 3 business days or less from the date the invoice is sent. Employer has negotiated a non-standard payment arrangement whereby the Invoice Due Date set forth in the invoice will be 5 business days following the date that the invoice is sent. The fee for this arrangement is waived for this Agreement Period.

**Section 4. Paid Claims, Billing Cycle and Payment Method**

**A. Paid Claims**

Paid Claims are described in Article 1-Paid Claims Definition of the Agreement.

**B. Billing Cycle**

Weekly

Anthem shall notify Employer of the amount due to Anthem as a result of Claims processed and paid by Anthem according to the billing cycle described above. The actual date of notification of Paid Claims and the Invoice Due Date will be determined according to Anthem's regular business practices and systems capabilities.

**C. Payment Method**

ACH Demand Debit Reimbursement for Paid Claims. Anthem will initiate an ACH demand debit transaction that will withdraw the amount due from a designated Employer bank account no later than the next business day following the Invoice Due Date, however, if the Invoice Due Date falls on either a banking holiday, a Saturday or a Sunday, the withdrawal shall be made on the following banking day.

**Section 5. Administrative Services Fee Billing Cycle and Payment Method**

**A. Billing Cycle**

Self-Bill. The Invoice Due Date is the 15th of each month and funds are due on that day.

Anthem shall notify Employer of the amount due to Anthem pursuant to Section 3 of Schedule A according to the billing cycle described above. The actual date of notification of amounts due and the Invoice Due Date will be determined according to Anthem's regular business practices and systems capabilities.

**B. Payment Method**

ACH or Wire Transfer Reimbursement. Employer shall deposit the amount due in a designated Anthem bank account by the Invoice Due Date. The deposit shall be made in accordance with any policies and regulations of the bank necessary to assure that the deposit is credited to Anthem's account no later than the next business day.

**Section 6. Claims Runout Services**

**A. Claims Runout Period**

Claims Runout Period shall be for the 12 months following the date of termination of this Agreement.

**B. Claims Runout Administrative Services Fees**

Medical:

The fee for Claims Runout Services is included in the Base Administrative Services Fees in Section 3(A) of this Schedule A. Fees in Sections 3(B) and 3(C) of this Schedule A that (i) are associated with Claims processed or reviewed during the Claims Runout Period including without limitation subrogation fees, Claims prepayment analysis fees, recovery fees, network access fees; or (ii) apply to the Agreement Period but were not billed during the Agreement Period, will be billed and payable during the Claims Runout Period. Payment is due to Anthem by the Invoice Due Date.

**Section 7. Inter-Plan Arrangements:**

The following Inter-Plan Arrangement-related fees are included in the Base Administrative Services Fee: Access Fees paid to Host Blues, the Administrative Expense Allowance ("AEA") Fee, Central Financial Agency Fees, ITS Transaction Fees, Blue Cross Blue Shield Global Core® Program services Fees and any Negotiated Arrangement Fees.

**Section 8. Other Amendments. The Administrative Services Agreement is otherwise amended as follows:**

**Blue Cross Blue Shield Global Core**

All references to BlueCard Worldwide are replaced by Blue Cross Blue Shield Global Core.

**Notice of Loss of Grandfathering Status**

In the event Employer maintains a grandfathered health plan(s), as that term is used in the Patient Protection and Affordable Care Act ("PPACA"), Employer shall not make any changes to such plan(s), including, but not limited to, changes with respect to Employer contribution levels, without providing Anthem with advance written notice of the intent to change such plan(s). Making changes to grandfathered plans without notice to Anthem may result in the plan(s) losing grandfathered status and significant penalties and/or fines to Employer and Anthem. In the event Employer implements changes to its plan(s) and does not provide advance notice to Anthem, Employer agrees to indemnify Anthem according to the indemnification provisions set forth elsewhere in this Agreement for any penalties, fines or other costs assessed against Anthem.

Additionally, at each renewal after September 23, 2010, Employer shall affirm in writing, upon reasonable request of Anthem, that it has not made changes to its plan(s) that would cause the plan(s) to lose its/their grandfathered status.

If Employer loses grandfathered Plan status under PPACA and notifies Anthem of such loss no fewer than 90 days before the effective date of the change, Anthem will implement the additional group market (insurance) reforms that apply to non-grandfathered health Plans subject to the provisions of Article 18 of this Agreement.

HealthKeepers, Inc. and Anthem Health Plans of  
Virginia, Inc. dba Anthem Blue Cross and Blue Shield



By: John Hogan  
Title: RVP Underwriting II  
Date: March 30, 2020



**SCHEDULE B  
TO  
ADMINISTRATIVE SERVICES AGREEMENT  
WITH  
OWENS & MINOR, INC.**

This Schedule B shall govern the Agreement Period from January 1, 2020 through December 31, 2020. For purposes of this Agreement Period, this Schedule B shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules and this Schedule B, the terms of this Schedule B shall control.

The following is a list of services that Anthem will provide under this Agreement for the Base Administrative Services Fee listed in Section 3(A) of Schedule A. These services will be furnished to Employer in a manner consistent with Anthem's standard policies and procedures for self-funded plans.

Anthem may also offer additional, optional services to Employer, and such services, whether or not purchased by Employer, are not included in the services set forth below in this Schedule B. By way of example and not limitation, Anthem may offer certain optional programs that include utilization management activities. In such event, the services associated with those programs are not included in the services described below. Services under Article 13 will only be pursued or performed for Claims associated with these programs or that would have been impacted by these programs if the programs are purchased by Employer. If Employer has purchased such services, those services and any additional fees are also listed in Schedule A.

**SERVICES INCLUDED IN THE BASE ADMINISTRATIVE SERVICES FEE IN SECTION 3A OF SCHEDULE A**

**Management Services**

Anthem's benefits and administration as described in this paragraph:

- Anthem definitions, and exclusions
- Anthem complaint and appeals process (One mandatory level of appeal, one voluntary level of appeal)
- Claims incurred and paid as provided in Schedule A, excluding activities related to Claim recovery
- Accumulation toward plan maximums beginning at zero on effective date
- Anthem Claim forms
- ID card
- Explanation of Benefits (Non-customized)
- Acceptance of electronic submission of eligibility information in HIPAA-compliant format
- Preparation of Benefits Booklet (accessible via internet)
- Information for ERISA 5500
- Account reporting - standard data reports
- Standard billing and banking services
- Plan Design consultation
- Employer eServices
  - Add and delete Members
  - Download administrative forms
  - View Member Benefits and request ID cards
  - View eligibility
  - View Claim status and detail
- Responsible Reporting Entity for the Plan
- Information for preparation of SBC

### **Claims and Customer Services**

- Claims processing services
- Medicare crossover processing
- Employer customer service, standard business hours
- Member customer service, standard business hours
- 1099s prepared and delivered to Providers
- Residency-based assessments and/or surcharges and other legislative reporting requirements
- Member eServices
- Member identity theft and credit monitoring and identity repair
- Women's Health and Cancer Rights Act notices

### **Care Management**

- Health Care Management
  - Referrals
  - Utilization management
  - Case management
  - Anthem Medical Policy
- SpecialOffers
- Transplant services - Blues Distinction
- Healthy Solutions Newsletter (available online)
- MyHealth (Member Portal)
  - Electronic Health Risk Assessment
  - Personal Health Record
  - Online Communities
  - Member Alerts

### **Networks**

- Access to networks
  - Provider Network
  - Mental Health/Substance Abuse Network
  - Coronary Services Network
  - Human Organ and Tissue Transplant Network
  - Complex and Rare Cancer Network
  - Bariatric Surgery Network
- Network Management
- Online Provider directory

HealthKeepers, Inc. and Anthem Health Plans of  
Virginia, Inc. dba Anthem Blue Cross and Blue Shield



By: John Hogan  
Title: RVP Underwriting II  
Date: March 30, 2020

**SCHEDULE C**  
**Performance Guarantees**  
**Mercer Health Advantage Model**  
**TO ADMINISTRATIVE SERVICES AGREEMENT**  
**WITH**  
**OWENS & MINOR, INC.**

This Schedule C provides certain guarantees pertaining to Anthem's performance under the Agreement between the Parties (Performance Guarantees) and shall be effective for the period from January 1, 2020 through December 31, 2021 (the Performance Period), unless otherwise indicated herein. Descriptions of the terms of each Performance Guarantee applicable to the Parties are set forth in the Attachments (the Attachments) to this Schedule C and made a part of this Schedule C. This Schedule shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules and this Schedule C, the terms of this Schedule C shall control.

**Section 1. General Conditions**

- A. The Performance Guarantees described in the Attachments to this Schedule C shall be in effect only for the Performance Period indicated above, unless specifically indicated otherwise in the Attachments. The Performance Guarantees shall also contain a measurement period (the Measurement Period) for which any Performance Guarantee will be calculated. If there are any inconsistencies between the terms contained in this Schedule, and the terms contained in any of the Attachments to this Schedule C, the terms of the Attachments to this Schedule C shall control.
- B. Anthem shall conduct an analysis of the data necessary to calculate any one of the Performance Guarantees within the timeframes provided in the Attachments to this Schedule C. In addition, any calculation of Performance Guarantees, reports provided, or analysis performed by Anthem shall be based on Anthem's then current measurement methodology.
- C. Any audits performed by Anthem to test compliance with any of the Performance Guarantees shall be based on a statistically valid sample size with a 95% confidence level.
- D. If the Parties do not have an executed Agreement, Anthem shall have no obligation to make payment under these Performance Guarantees.
- E. Unless otherwise provided in the Attachments to this Schedule, the measurement of the Performance Guarantee shall be based on: (1) the performance of any service team, business unit, or measurement group assigned by Anthem; and (2) data that is maintained and stored by Anthem or its Vendors, subject to the following:
  - For Operations Performance Guarantees, for employers with 20,000 or more Members on average during the Performance Period, all Guarantees will be based on employer-specific results, except call quality and appeals will be based on Mercer Health Advantage results.
  - For Operations Performance Guarantees, for employers with 5,000 or more Subscribers but fewer than 20,000 Members on average during the Performance Period, all Guarantees will be based on employer-specific results, except financial accuracy, Claims accuracy, call quality and appeals will be based on Mercer Health Advantage results.
  - For Operations Performance Guarantees, for employers with fewer than 5,000 Subscribers on average during the Performance Period, all Guarantees will be based on Mercer Health Advantage results, except account management satisfaction, reporting ID cards, eligibility, implementation and discounts will be based on employer-specific results.

This is illustrated in Exhibit 1 to this Schedule C.

- F. If Employer terminates the Agreement between the Parties prior to the end of the Performance Period, or if the Agreement is terminated for non-payment, then Employer shall forfeit any right to collect any further payments under any outstanding Performance Guarantees, whether such Performance Guarantees are for a prior or current Measurement Period or Performance Period.
- G. Anthem reserves the right to make changes to any of the Performance Guarantees provided in the Attachments to this Schedule C upon the occurrence, in Anthem's determination, of:

- 1) a change to the Plan benefits or the administration of the Plan initiated by Employer that results in a substantial change in the services to be performed by Anthem or the measurement of a Performance Guarantee;
- 2) Employer no longer purchasing Mercer Health Advantage; or
- 3) Enrollment in Plan's administered by Anthem is less than 3,000 Members.

Should there be a change in occurrence as indicated above and these changes negatively impact Anthem's ability to meet the Performance Guarantees, Anthem shall have the right to modify the Performance Guarantees contained in the Attachments.

- H. For the purposes of calculating compliance with the Performance Guarantees contained in the Attachments to this Schedule C, if a delay in performance of, or inability to perform, a service underlying any of the Performance Guarantees is due to circumstances which are beyond the control of Anthem, including but not limited to any act of God, civil riot, floods, fire, acts of terrorists, acts of war or power outage, such delayed or non-performed service will not count towards the measurement of the applicable Performance Guarantee.

## **Section 2. Payment:**

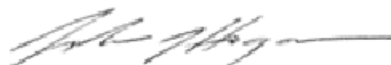
- A. If Anthem fails to meet any of the obligations specifically described in a Performance Guarantee, Anthem shall pay Employer the amount set forth in the Attachment describing the Performance Guarantee. Payment shall be in the form of a credit on Employer's invoice for Administrative Services Fees which will occur annually unless otherwise stated in the Performance Guarantee.
- B. Notwithstanding the above, Anthem has the right to offset any amounts owed to Employer under any of the Performance Guarantees contained in the Attachments to this Schedule C against any amounts owed by Employer to Anthem under: (1) any Performance Guarantees contained in the Attachments to this Schedule C; (2) the Agreement, or (3) any applicable Stop Loss Policy.
- C. Notwithstanding the foregoing, Anthem's obligation to make payment under the Performance Guarantees is conditioned upon Employer's timely performance of its obligations provided in the Agreement in this Schedule C and the Attachments, including providing Anthem with the information or other support required by Anthem in the Attachments. If Employer or its vendors take actions that adversely impact Anthem's ability to meet the Performance Guarantee or fail to meet any obligations provided in the Attachments related to such Performance Guarantee, Anthem shall not be obligated to make payment under a Performance Guarantee.

## **Section 3. Maximum Amount Payable under the Performance Guarantees**

Notwithstanding any other provision contained in this Schedule or the Attachments to this Schedule, the maximum amount Anthem shall be obligated to pay to Employer is equal to the sum of:

- Implementation Guarantees (Year One): 5% of Discounted Administrative Services Fees
- Operations Guarantees: 25% of Discounted Administrative Services Fees
- Clinical Guarantees: 30% of Discounted MHA Fees

HealthKeepers, Inc. and Anthem Health Plans of  
Virginia, Inc. dba Anthem Blue Cross and Blue Shield



By: John Hogan  
Title: RVP Underwriting II  
Date: March 30, 2020

Performance Category	Annual Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
Implementation	3.0% of Admin. Services Fees	A minimum of 97% of all tasks will be completed by the dates specified in the implementation plan agreed to by the Parties. The implementation plan will be developed by Anthem and will contain tasks to be completed by Employer and/or Anthem and a timeframe for completion of each task. The implementation plan will also contain Measurement Periods specific to each task. Anthem's payment under this Guarantee is conditioned upon Employer's completion of all designated tasks by the dates specified in the implementation plan.	100% of Amount at Risk		<b>Measurement Period</b> Defined in Implementation Plan  <b>Reporting Period</b> 60 calendar days following the end of the implementation period
Implementation Survey	2.0% of Admin. Services Fees	A minimum average score of 3.0 will be attained on the Implementation Survey. Anthem will prepare and send an Implementation Survey to Employer. Anthem will only consider survey results received within 30 calendar days from the delivery of the survey to the Employer.	100% of Amount at Risk		<b>Measurement Period</b> Annual  <b>Reporting Period</b> 60 calendar days following Anthem's receipt of the survey
Claims Timeliness (14 Calendar Days)	1.0% of Admin. Services Fees	A minimum of 92% of Non-investigated medical Claims will be processed timely. Non-investigated Claims are defined as medical Claims that process through the system without the need to obtain additional information from the Provider, Subscriber or other external sources. Processed Timely is defined as Non-investigated medical Claims that have been finalized within 14 calendar days of receipt.  This Guarantee will be calculated based on the number of Non-investigated Claims that Processed Timely divided by the total number of Non-investigated Claims. The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented.	<b>Result</b>	<b>Penalty</b>	<b>Measurement Period</b> Annual  <b>Reporting Period</b> Quarterly
			92.0% or Greater	None	
			91.0% to 91.9%	25%	
			90.0% to 90.9%	50%	
Claim Timeliness (30 Calendar Days)	1.0% of Admin. Services Fees	A minimum of 99% of Non-investigated medical Claims will be processed timely. Non-investigated medical Claims are defined as Claims that process through the system without the need to obtain additional information from the Provider, Subscriber or other external sources. Processed Timely is defined as Non-investigated medical Claims that have been finalized within 30 calendar days of receipt.  This Guarantee will be calculated based on the number of Non-investigated Claims that Processed Timely divided by the total number of Non-investigated Claims. The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented.	Less than 90.0%	100%	
			99.0% or Greater	None	<b>Measurement Period</b> Annual  <b>Reporting Period</b> Quarterly
			98.0% to 98.9%	25%	
			97.0% to 97.9%	50%	
Claims Financial Accuracy	2.0% of Admin. Services Fees	A minimum of 99.2% of medical Claim dollars will be processed accurately. This Guarantee will be calculated based on the total dollar amount of audited medical Claims paid correctly divided by the total dollar amount of audited medical Paid Claims. The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented.	Less than 97.0%	100%	
			99.2% or Greater	None	<b>Measurement Period</b> Annual  <b>Reporting Period</b> Quarterly
			98.6% to 99.1%	25%	
			98.0% to 98.5%	50%	
			Less than 98.0%	100%	

Performance Category	Annual Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
Claims Accuracy	3.0% of Admin. Services Fees	A minimum of 98% of medical Claims will be paid or denied correctly. This Guarantee will be calculated based on the number of audited medical Claims paid and denied correctly divided by the total number of audited medical Claims paid and denied. The calculation of this Guarantee excludes in any quarter Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented.	<b>Result</b> 98.0% or Greater 96.0% to 97.9% 95.0% to 95.9% Less than 95.0%	<b>Penalty</b> None 25% 50% 100%	<b>Measurement Period</b> Annual  <b>Reporting Period</b> Quarterly
Processing of Ongoing Eligibility Information	2.0% of Admin. Services Fees	100% of Employer's ongoing electronic eligibility files will be processed timely. Timely Processing is defined as electronic eligibility files processed and updated on the eligibility database within 5 business days of receipt of an eligibility file. This Guarantee only applies to the processing of eligibility files submitted by Employer outside of an open enrollment period. This Guarantee does not apply to a defective eligibility file. A Defective Eligibility File is defined as an eligibility file that has issues that prevent Anthem's processing of the file. Anthem's payment of this Guarantee is conditioned upon receipt of eligibility files in a format mutually agreed upon by the Parties.  This Guarantee will be calculated by (1) dividing the total number of eligibility files processed within the timeframe set forth above by (2) the number of Employer's eligibility files processed.	100% of Amount at Risk		<b>Measurement Period</b> Annual  <b>Reporting Period</b> Quarterly
Ongoing ID Cards Issuance	None	A minimum of 99% of Subscriber digital ID cards will be available or Member physical ID cards will be mailed to Members within 10 business days of Anthem's processing of an Accurate Eligibility File. An Accurate Eligibility File is defined as : (1) an eligibility file formatted in a mutually agreed upon manner; (2) received by Anthem outside of an open enrollment period; and, (3) contains an error rate of less than 1%. This Guarantee will be calculated based on the total number of ongoing ID cards available to Subscribers or mailed to Members within the timeframe set forth above divided by the total number of Members eligible to receive ongoing ID cards. This Guarantee does not include digital cards for Anthem Dental services.	Not Applicable		<b>Measurement Period</b> Annual  <b>Reporting Period</b> Quarterly
Average Speed to Answer	2.0% of Admin. Services Fees	The average speed to answer (ASA) will be 30 seconds or less. ASA is defined as the average number of whole seconds members wait and/or are in the telephone system before receiving a response from a customer care representative (CCR) or an interactive voice response (IVR) unit. This Guarantee will be calculated based on the total number of calls received in the customer service telephone system.	<b>Result</b> 30 seconds or less 30.1 to 34.0 seconds 34.1 to 38 seconds More than 38 seconds	<b>Penalty</b> None 25% 50% 100%	<b>Measurement Period</b> Annual  <b>Reporting Period</b> Quarterly
Call Abandonment Rate	1.0% of Admin. Services Fees	A maximum of 2.5% of member calls will be abandoned. Abandoned Calls are defined as member calls that are waiting for a customer care representative (CCR), but are abandoned before connecting with a CCR. This Guarantee will be calculated based on the number of calls abandoned divided by the total number of calls received in the customer service telephone system. Calls that are abandoned in less than five seconds will not be included in this calculation.	<b>Result</b> 2.5% or Less 2.51% to 2.75% 2.76% to 2.99% 3.00% or Greater	<b>Penalty</b> None 25% 50% 100%	<b>Measurement Period</b> Annual  <b>Reporting Period</b> Quarterly
First Call Resolution	2.0% of Admin. Services Fees	A minimum of 90% of member calls will be resolved during the initial contact with no further follow up required. First Call Resolution is defined as member callers receiving a response to their inquiry during an initial contact with no further follow-up required. This Guarantee will be calculated based on the total number of members who receive a First Call Resolution divided by the total number of calls received into the customer service telephone system.	<b>Result</b> 90.0% or Greater 88.0% to 89.9% 86.0% to 87.9% Less than 86.0%	<b>Penalty</b> None 25% 50% 100%	<b>Measurement Period</b> Annual  <b>Reporting Period</b> Quarterly



Performance Category	Annual Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period	
Dedicated Customer Service Staff Assignment Reporting	None	An annual report will be provided to Employer detailing those associates assigned to the designated Customer Service team for employers who have purchased Mercer Health Advantage. Quarterly updates to this annual report will be provided no later than 30 calendar days following the end of the quarter.	Not Applicable		Measurement Period Annual  Reporting Period Quarterly	
Member Satisfaction - NPS	4.0% of Admin. Services Fees	This Guarantee establishes a Quality Benchmark transactional Net Promoter Score (NPS) of 40. Anthem will either: (i) meet or exceed the Quality Benchmark; or, (ii) there will be an improvement in the Net Promoter Score from the Baseline Period.  The survey is conducted after a member contacts a customer service representative (CSR). Each member who completes a transaction with Anthem will be asked to provide a rating on a scale from 0 (Not at All Likely) to 10 (Extremely Likely) to a question that asks how likely the member would recommend Anthem to a friend or colleague based on the member's most recent transaction. The transactional Net Promoter Score will be calculated by subtracting the percentage of Detractors (members who provide a rating from 0 to 6) from the percentage of Promoters (members who provide a rating of 9 or 10).  To determine the results for (i), Anthem shall compare the Net Promoter Score in the Measurement Period to the Quality Benchmark.  The improvement for (ii) will be determined by comparing the Net Promoter Score in the Measurement Period to the Net Promoter Score in the Baseline Period.  The Baseline Period is the equivalent time period preceding the Measurement Period.	Result	Penalty	Measurement Period	
			Net Promoter Score increased	None	Annual	
			OR			Reporting Period
			If Net Promoter Score stayed the same or decreased AND is		Annual	
			40 or Greater	None		
			39.0 to 39.9	25%		
			38.0 to 38.9	50%		
			Less than 38.0	100%		
Management Reports	None	Standard automated reports will be made available to Employer by no later than 25 calendar days following the end of the month. The reports will include financial, utilization and clinical information.	Not Applicable		Measurement Period Annual  Reporting Period Annual	
Account Management Satisfaction	5.0% of Admin. Services Fees	A minimum average score of 3.5 will be attained on the Account Management Satisfaction Survey (AMSS). A minimum of 3 responses per Employer to the AMSS is required to base the score on Employer-specific responses only. If 3 responses are received from the Employer, an average score is calculated by adding the scores from each respondent divided by the total number of Employer respondents. If fewer than 3 responses are received, the score will be calculated as follows:  2 Employer responses: 2/3 of the score will be based on Employer-specific AMSS results and 1/3 of the score will be based on the aggregate score of all AMSS results received by the Account Management Team.  1 Employer-response: 1/3 of the score will be based on Employer-specific AMSS results and 2/3 of the score will be based on the aggregate score of all AMSS results received by the Account Management Team.  0 Employer responses: The score will be based on the aggregate score of all AMSS results received by the Account Management Team.	Result	Penalty	Measurement Period	
			3.5 or higher	None	Annual	
			3.0 to 3.4	25%		
			2.5 to 2.9	50%	Reporting Period	
			Less than 2.5	100%	Annual	



Performance Category	Annual Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
Appeals	2% of Admin. Services Fees	<p>A minimum of 96% of all appeals will be resolved in accordance with the following Department of Labor required timeframes:</p> <p>1) Urgent Care Claims: Not later than 72 hours after receipt by Anthem's Grievance and Appeals Department of the claimant's request for review of an adverse benefit determination by Anthem.</p> <p>2) Pre-service Claims: a) Where Employer offers one mandatory level of appeal of an adverse benefit determination - Not later than 30 days after receipt by Anthem's Grievance and Appeals Department of the claimant's request for review of an adverse benefit determination; or b) Where the Employer offers two mandatory levels of appeal of an adverse benefit determination - Not later than 15 days after receipt by Anthem's Grievance and Appeals Department of the claimant's request for review of the adverse benefit determination.</p> <p>3) Post-service Claims: a) Where the Employer offers one mandatory level of appeal of an adverse benefit determination - Not later than 60 days after receipt by Anthem's Grievance and Appeals Department of the claimant's request for review of an adverse benefit determination; or b) Where the Employer offers two mandatory levels of appeal of an adverse benefit determination - Not later than 30 days after receipt by Anthem's Grievance and Appeals Department of the claimant's request for review of the adverse benefit determination.</p> <p>This Guarantee will be calculated based on the number of appeals resolved in accordance with the above timeframes set forth by the DOL divided by the total number of appeals.</p>	Result	Penalty	<u>Measurement Period</u>
			96.0% or Greater	None	Annual
			93.5% to 95.9%	25%	
			92.0% to 93.4%	50%	<u>Reporting Period</u>
			Less than 92%	100%	Quarterly

**ATTACHMENT 2 TO SCHEDULE C**  
**Performance Guarantees**  
**Mercer Health Advantage Model**  
**TO ADMINISTRATIVE SERVICES AGREEMENT**  
**WITH**  
**OWENS & MINOR, INC.**

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
Mercer Health Advantage Return on Investment	10% of MHA Fees	<p>The Return on Investment (ROI) will be 2:1.</p> <p>The Return on Investment (ROI) is defined as gross savings divided by the program fees. The calculation methodology used to estimate gross savings shall be mutually agreed upon by Mercer and Anthem.</p>	<p><b>Result</b></p> <p>2.00:1.00 or Greater</p> <p>1.50:1 to 1.99:1</p> <p>Below 1.50:1</p>	<p><b>Penalty</b></p> <p>None</p> <p>75%</p> <p>100%</p>	<p><u><b>Measurement Period</b></u></p> <p>Annual</p> <p><u><b>Reporting Period</b></u></p> <p>Annual</p>
Inpatient Admission	2% of MHA Fee	<p>This Guarantee establishes a Quality Benchmark of 34 or less Inpatient Admissions per 1,000 Members (IP Admission Rate). Inpatient Admissions are defined as admissions with Type of Service categories of Medical, Surgical and Behavioral Health. Admissions do not include admissions related to Type of Service categories of Maternity, NICU or Rehabilitation.</p> <p>Anthem will either: (i) meet or exceed the benchmark; or, (ii) there will be a 2% reduction in the IP Admission Rate from the Measurement Period compared to the Baseline Period.</p> <p>Only Members, for whom Anthem has at least 6 months of eligibility information in a Measurement Period, shall be considered for purposes of this Guarantee. To calculate the IP Admission Rate, Anthem shall divide (a) the IP Admissions during the Measurement Period by (b) the number of Identified Members for such Measurement Period. In determining (b) above, Anthem shall weight the number of those Identified Members by the actual number of months that Anthem had eligibility information for those Identified Members.</p> <p>To determine the results for (i), Anthem shall compare the IP Admission Rate to the Quality Benchmark. To determine the results for (ii), Anthem shall compare the IP Admission Rate for the Measurement Period to the IP Admission Rate for the Baseline Period.</p>	100% of Amount at Risk		<p><u><b>Measurement Period</b></u></p> <p>Annual</p> <p><u><b>Reporting Period</b></u></p> <p>Annual</p>
Avoidable ER Visit Rate	2% of MHA Fee	<p>This guarantee establishes a Quality Benchmark of 65 or less avoidable Emergency Room Visits per 1,000 Members (Avoidable ER Visit Rate). Avoidable Emergency Room Visits are defined as low intensity Emergency Room Visits on the high impact diagnosis list as determined according to Anthem's criteria. Avoidable Emergency Room Visits do not include any Emergency Room Visits that result in an Inpatient Admission.</p> <p>Anthem will either: (i) meet or exceed the Quality Benchmark; or, (ii) there will be a 2% reduction in the Avoidable ER Visit Rate for the Measurement Period compared to the Baseline Period.</p> <p>Only Identified Members, for whom Anthem has at least 6 months of eligibility information in a Measurement Period, shall be considered for purposes of this Guarantee. To calculate the Avoidable ER Visit Rate, Anthem shall divide (a) the Avoidable ER Visits during the Measurement Period by (b) the number of Identified Members for such Measurement Period. In determining (b) above, Anthem shall weight the number of those Identified Members by the actual number of months that Anthem had eligibility information for those included Identified Members.</p> <p>To determine the results for (i), Anthem shall compare the Avoidable ER Visit Rate to the Quality Benchmark. To determine the results for (ii), Anthem shall compare the ER Visit Rate for the Measurement Period to the ER Visit Rate for the Baseline Period.</p>	100% of Amount at Risk		<p><u><b>Measurement Period</b></u></p> <p>Annual</p> <p><u><b>Reporting Period</b></u></p> <p>Annual</p>

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
30-day Readmission Rate	2% of MHA Fee	<p>This Guarantee establishes a Quality Benchmark of 9 or less readmissions per 100 admissions (IP Readmission Rate). The IP Readmission Rate is defined as the rate of Inpatient Readmissions for Identified Members that occur within 30 days of discharge from an inpatient stay. The readmissions included to calculate compliance with this Performance Guarantee shall: (a) include acute inpatient stays for Members who are 18 years of age and older during the Measurement Period that were followed by an acute readmission for any diagnosis within 30 days; and, (b) exclude stays that meet the exclusion criteria such as those related to pregnancy and birth, or with a discharge code of death, or rehabilitation-specific admissions.</p> <p>Anthem will either: (i) meet or exceed the Benchmark; or, (ii) there will be a 2% reduction in the Inpatient Readmission Rate for the Measurement Period compared to the Baseline Period.</p> <p>Only Identified Members, for whom Anthem has at least 6 months of eligibility information in a Measurement Period, shall be considered for purposes of this Guarantee.</p> <p>To determine the results for (i), Anthem shall compare the IP Readmission Rate to the Quality Benchmark. To determine the results for (ii), Anthem shall compare the IP Readmission Rate for the Measurement Period to the IP Readmission Rate for the Baseline Period.</p>	100% of Amount at Risk	<p><b><u>Measurement Period</u></b></p> <p>Annual</p> <p><b><u>Reporting Period</u></b></p> <p>Annual</p>
Member Satisfaction with MHA Program	2% of MHA Fee	<p>A minimum of 85% of actively managed members who are age 18-64 will be satisfied with the MHA Program as shown by one satisfaction question in a survey provided by Anthem. Actively Managed Members are those who have participated in one or more MHA programs. The survey will be given to a random sample of Anthem members who have participated in one or more MHA Programs. The question will request that members evaluate their satisfaction with the MHA Programs. Results for this Performance Guarantee will be calculated by dividing (i) the total number of Actively Managed Members who respond positively by (ii) the total number of Actively Managed Members who answered the question. This Performance Guarantee will be based on all MHA members unless 30 or more Members of Employer's Plan respond, in which event the results shall be measured based on the responses of Employer's Members.</p>	100% of Amount at Risk	<p><b><u>Measurement Period</u></b></p> <p>Annual</p> <p><b><u>Reporting Period</u></b></p> <p>Annual</p>
Diabetes A1C Level	3% MHA Fee	<p>This Guarantee establishes a Quality Benchmark of 40% in the percentage of Identified Members with diabetes and for whom Anthem received test results with A1c levels less than or equal to 7.0 (Test Result Percentage). Anthem will either: (i) meet or exceed the Quality Benchmark; or, (ii) there will be a minimum improvement of 5% in the Test Result Percentage as compared to the difference between the Quality Benchmark and the Test Result Percentage from the Baseline Period.</p> <p>The Test Result Percentage will be calculated based on the number of Identified Members with diabetes for whom Anthem received test results with A1c levels less than or equal to 7.0 during the Measurement Period divided by the total number of Identified Members.</p> <p>To determine the results for (i), Anthem shall compare the Test Result Percentage in the Measurement Period to the Quality Benchmark.</p> <p>The improvement percentage for (ii) will be calculated by: 1) subtracting the Test Result Percentage in the Baseline Period from the Test Result Percentage in the Measurement Period; and, 2) dividing the result by the difference between the Quality Benchmark and the Test Result Percentage Baseline Period.</p> <p>Only Members for whom Anthem has at least 12 months of eligibility information shall be considered Identified Members for purposes of this Guarantee.</p>	100% of Amount at Risk	<p><b><u>Measurement Period</u></b></p> <p>Annual</p> <p><b><u>Reporting Period</u></b></p> <p>Annual</p>

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
Diabetes Nephropathy	3% of MHA Fee	<p>This Guarantee establishes a Quality Benchmark of 75% in the percentage of Identified Members with diabetes who received a nephropathy screening test or had evidence of nephropathy. (Testing/Identification Rate). Anthem will either: (i) meet or exceed the Quality Benchmark; or, (ii) there will be a minimum improvement of 5% in the Testing/Identification Rate as compared to the difference between the Quality Benchmark and the Testing/Identification Rate for the Baseline Period.</p> <p>The Testing/Identification Rate will be calculated based on the number of Identified Members with diabetes and who received a nephropathy screening test, or had evidence of nephropathy during the Measurement Period, divided by the total number of Identified Members.</p> <p>To determine the results for (i), Anthem shall compare the Testing/Identification Rate in the Measurement Period to the Quality Benchmark.</p> <p>The improvement percentage for (ii) will be calculated by: 1) subtracting the Testing/Identification Rate in the Baseline Period from the Testing/Identification Rate in the Measurement Period; and, 2) dividing the result by the difference between the Quality Benchmark and the Testing/Identification Rate for the Baseline Period.</p> <p>Only Members for whom Anthem has at least 12 months of eligibility information shall be considered Identified Members for purposes of this Guarantee.</p>	100% of Amount at Risk	<p><b><u>Measurement Period</u></b></p> <p>Annual</p> <p><b><u>Reporting Period</u></b></p> <p>Annual</p>
CAD – Statin Medication Usage	3% of MHA Fee	<p>This Guarantee establishes a Quality Benchmark of 65% in the percentage of Identified Members with coronary artery disease (CAD) who are dispensed one or more statin medications (Dispense Rate). Anthem will be either (i) meet or exceed the Quality Benchmark; or, (ii) there will be a minimum improvement of 5% in the Dispense Rate as compared to the difference between the Quality Benchmark and the Dispense Rate for the Baseline Period.</p> <p>The Dispense Rate will be calculated based on the total number of Identified Members with CAD who are dispensed 1 or more statin medications during the Measurement Period divided by the total number of Identified Members.</p> <p>To determine the results for (i), Anthem shall compare the Dispense Rate in the Measurement Period to the Quality Benchmark.</p> <p>The improvement percentage for (ii) will be calculated by: 1) subtracting the Dispense Rate in the Baseline Period from the Dispense Rate in the Measurement Period; and, 2) dividing the result by the difference between the Quality Benchmark and the Dispense Rate for the Baseline Period.</p> <p>Only Members for whom Anthem has at least 12 months of eligibility information shall be considered Identified Members for purposes of this Guarantee.</p>	100% of Amount at Risk	<p><b><u>Measurement Period</u></b></p> <p>Annual</p> <p><b><u>Reporting Period</u></b></p> <p>Annual</p>
Asthma Medication Usage	3% of MHA Fee	<p>This Guarantee establishes a Quality Benchmark of 85% in the percentage of Identified Members with persistent asthma who are dispensed 1 or more appropriate Prescription Drugs (Dispense Rate). Anthem will either: (i) meet or exceed the Quality Benchmark; or, (ii) there will be a minimum improvement of 5% in the Dispense Rate as compared to the difference between the Quality Benchmark and the Dispense Rate for the Baseline Period.</p> <p>The Dispense Rate will be calculated based on the number of Identified Members with persistent asthma who are dispensed 1 or more appropriate Prescription Drugs during the Measurement Period divided by the total number of Identified Members.</p> <p>To determine the results for (i), Anthem shall compare the Dispense Rate in the Measurement Period to the Quality Benchmark.</p> <p>The improvement percentage for (ii) will be calculated by: 1) subtracting the Dispense Rate in the Baseline Period from the Dispense Rate in the Measurement Period; and, 2) dividing the result by the difference between the Quality Benchmark and the Dispense Rate for the Baseline Period</p> <p>Only Members for whom Anthem has at least 12 months of eligibility information shall be considered Identified Members for purposes of this Guarantee.</p>	100% of Amount at Risk	<p><b><u>Measurement Period</u></b></p> <p>Annual</p> <p><b><u>Reporting Period</u></b></p> <p>Annual</p>

Measure	Less than 5,000 Subscribers	5,000 Subscribers or More and Less than 20,000 Members	20,000 Members or More
<b>Operations Performance Guarantees</b>			
Implementation	Employer-Specific	Employer-Specific	Employer-Specific
Implementation Survey	Employer-Specific	Employer-Specific	Employer-Specific
Claims Timeliness (14 Calendar Days)	MHA Book of Business	Employer-Specific	Employer-Specific
Claims Timeliness (30 Calendar Days)	MHA Book of Business	Employer-Specific	Employer-Specific
Claims Financial Accuracy	MHA Book of Business	MHA Book of Business	Employer-Specific
Claims Payment Accuracy	MHA Book of Business	MHA Book of Business	Employer-Specific
Processing Eligibility	Employer-Specific	Employer-Specific	Employer-Specific
ID Cards	Employer-Specific	Employer-Specific	Employer-Specific
Average Speed of Answer	MHA Book of Business	Employer-Specific	Employer-Specific
Call Abandonment Rate	MHA Book of Business	Employer-Specific	Employer-Specific
First Call Resolution	MHA Book of Business	Employer-Specific	Employer-Specific
Member Satisfaction - NPS	MHA Book of Business	Employer-Specific	Employer-Specific
Management Reports	Employer-Specific	Employer-Specific	Employer-Specific
Account Management Satisfaction	Employer-Specific if 3 responses or more	Employer-Specific if 3 responses or more	Employer-Specific if 3 responses or more
Appeals	MHA Book of Business	MHA Book of Business	MHA Book of Business
<b>Care Management and Return on Investment Performance Guarantees</b>			
Return on Investment	MHA Book of Business	Employer-Specific <sup>1</sup>	Employer-Specific <sup>1</sup>
All Other Clinical Guarantees	MHA Book of Business	MHA Book of Business	MHA Book of Business

<sup>1</sup>Groups that have 15% or more change in membership will get MHA Book of Business ROI result.

## SCHEDULE C

### Performance Guarantees

#### TO ADMINISTRATIVE SERVICES AGREEMENT WITH Owens & Minor, Inc.

This Schedule C provides certain guarantees pertaining to Anthem's performance under the Agreement between the Parties ("Performance Guarantees") and shall be effective for the period from January 1, 2020 through December 31, 2020 (the "Performance Period"). Descriptions of the terms of each Performance Guarantee applicable to the Parties are set forth in the Attachments (the "Attachments") to this Schedule C and made a part of this Schedule C. This Schedule shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules and this Schedule C, the terms of this Schedule C shall control. If there are any inconsistencies between the terms contained in this Schedule, and the terms contained in any of the Attachments to this Schedule C, the terms of the Attachments to this Schedule C shall control.

#### **Section 1. General Conditions**

- I. The Performance Guarantees described in the Attachments to this Schedule C shall be in effect only for the Performance Period indicated above, unless specifically indicated otherwise in the Attachments. Each Performance Guarantee shall specify a/an:
  - (1) Performance Category. The term Performance Category describes the general type of Performance Guarantee.
  - (2) Reporting Period. The term Reporting Period refers to how often Anthem will report on its performance under a Performance Guarantee.
  - (3) Measurement Period. The term Measurement Period is the period of time under which Anthem's performance is measured, which may be the same as or differ from the period of time equal to the Performance Period.
  - (4) Penalty Calculation. The term Penalty Calculation generally refers to how Anthem's payment will be calculated, in the event Anthem does not meet the target(s) specified under the Performance Guarantee.
  - (5) Amount at Risk. The term Amount at Risk means the amount Anthem may pay if it fails to meet the target(s) specified under the Performance Guarantee.
- J. Anthem shall conduct an analysis of the data necessary to calculate any one of the Performance Guarantees within the timeframes provided in the Attachments to this Schedule C. In addition, any calculation of Performance Guarantees, reports provided, or analysis performed by Anthem shall be based on Anthem's then current measurement and calculation methodology, which shall be available to Employer upon request.
- K. Any audits performed by Anthem to test compliance with any of the Performance Guarantees shall be based on a statistically valid sample size with a 95% confidence level.
- L. If the Parties do not have an executed Agreement, Anthem shall have no obligation to make payment under these Performance Guarantees.
- M. Unless otherwise specified in the Attachments to this Schedule C, the measurement of the Performance Guarantee shall be based on data that is maintained and stored by Anthem or its Vendors.
- N. If Employer terminates the Agreement between the Parties prior to the end of the Performance Period, or if the Agreement is terminated for non-payment, then Employer shall forfeit any right to collect any further payments under any outstanding Performance Guarantees, whether such Performance Guarantees are for a prior or current Measurement Period or Performance Period.
- O. Anthem reserves the right to make changes to any of the Performance Guarantees provided in the Attachments to this Schedule C upon the occurrence, in Anthem's determination, of:
  1. a change to the Plan benefits or the administration of the Plan initiated by Employer that results in a substantial change in the services to be performed by Anthem or the measurement of a Performance Guarantee;

2. an increase or decrease of 10% or more of the number of Members that were enrolled for coverage on the latter of the effective date or renewal date of this Agreement
3. a change in law or regulation that materially impacts underwriting assumptions made at the time of offering such Performance Guarantees.

Should there be a change in occurrence as indicated above and these changes negatively impact Anthem's ability to meet the Performance Guarantees, Anthem shall have the right to modify the Performance Guarantees contained in the Attachments.

- P. For the purposes of calculating compliance with the Performance Guarantees contained in the Attachments to this Schedule C, if a delay in performance of, or inability to perform, a service underlying any of the Performance Guarantees is due to circumstances which are beyond the control of Anthem, or its Vendors, including but not limited to any act of God, civil riot, floods, fire, acts of terrorists, acts of war or power outage, such delayed or non-performed service will not count towards the measurement of the applicable Performance Guarantee.
- Q. Some Performance Guarantees measure and compare year to year performance. The term Baseline Period refers to the equivalent time period preceding the Measurement Period.
- R. As determined by Anthem, Performance Guarantees may be measured using either aggregated data or Employer-specific Data. The term Employer-specific Data means the data associated with Employer's Plan that has not been aggregated with other employer data. Performance Guarantees will specify if Employer-specific Data shall be used for purposes of measuring performance under the Performance Guarantee.
- K. If any Performance Guarantees are tied to a particular program and its components, such Performance Guarantees are only valid if Employer participates in the program and its components for the entirety of the Measurement Period associated with the Performance Guarantee.
- L. All Performance Guarantees in which Anthem will make outbound calls or will reach out through email or other means to members will exclude members who Anthem cannot reach due to incorrect or invalid telephone numbers, including numbers where permission is required by law but not provided, or those members who have requested that Anthem not contact them.

## **Section 2. Payment:**

- D. If Anthem fails to meet any of the obligations specifically described in a Performance Guarantee, Anthem shall pay Employer the amount set forth in the Attachment describing the Performance Guarantee. Payment shall be in the form of a credit on Employer's invoice for Administrative Services Fees, which will occur annually unless otherwise stated in the Performance Guarantee.
- E. Notwithstanding the above, Anthem has the right to offset any amounts owed to Employer under any of the Performance Guarantees contained in the Attachments to this Schedule C against any amounts owed by Employer to Anthem under: (1) any Performance Guarantees contained in the Attachments to this Schedule C; (2) the Agreement; or, (3) any applicable Stop Loss Policy.
- F. Notwithstanding the foregoing, Anthem's obligation to make payment under the Performance Guarantees is conditioned upon Employer's timely performance of its obligations provided in the Agreement in this Schedule C and the Attachments, including providing Anthem with the information or data required by Anthem in the Attachments. Anthem shall not be obligated to make payment under a Performance Guarantee if Employer or Employer's vendor's action or inaction adversely impacts Anthem's ability to meet any of its obligations provided in the Attachments related to such Performance Guarantee, which expressly includes but is not limited to Employer or its vendor's failure to timely provide Anthem with accurate and complete data or information in the form and format expressly required by Anthem.
- G. Where the Amount at Risk for a Performance Guarantee is on a percentage of a Per Subscriber Per Month (PSPM) fee basis, the Guarantee will be calculated by multiplying the PSPM amount by the actual annual enrollment during the Measurement Period.



### Section 3. Performance Guarantee Amounts at Risk

#### Amount at Risk

The total amount at risk for the below performance guarantees between Anthem and Owens & Minor shall not exceed the following:

- **Operations Guarantees:** 20% of Base Medical Administration fees

Confirmation of all applicable fees for the performance guarantees will be reflected in Employer's Schedule C.

#### Maximum Amount Payable

The maximum amount payable under all guarantees between Anthem and Owens & Minor shall not exceed.

The Maximum Amount Payable provisions above do not apply to Pharmacy-related Performance Guarantees.

HealthKeepers, Inc. and Anthem Health Plans of  
Virginia, Inc. dba Anthem Blue Cross and Blue Shield



By: John Hogan

Title: RVP Underwriting II

Date: March 30, 2020

**PHARMACY BENEFITS ADMINISTRATIVE SERVICES SCHEDULE  
TO  
ADMINISTRATIVE SERVICES AGREEMENT  
WITH  
Owens & Minor, Inc.**

This Pharmacy Benefits Administrative Services Schedule ("Pharmacy Services Schedule") is by and between Employer and IngenioRx, Inc., an Anthem Affiliate that will be referenced as the pharmacy benefits manager ("PBM") for the purposes of this Pharmacy Services Schedule. The Pharmacy Services Schedule supplements and amends the Agreement between the Parties and is effective as of January 1, 2020 ("Effective Date"). Description of the Pharmacy Services and applicable fees for such services are set forth in the Exhibits (the "Exhibits") to this Pharmacy Services Schedule and made a part of this Pharmacy Services Schedule. In the event of an inconsistency between the applicable provisions of this Pharmacy Services Schedule and the Agreement, the terms of this Pharmacy Services Schedule shall govern, but only as they relate to the Pharmacy Services. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect. If there are any inconsistencies between the terms contained in this Schedule, and the terms contained in any of the Exhibits to this Pharmacy Benefits Schedule, the terms of the Exhibits shall control.

- A. **Definitions.** The following definitions apply to this Pharmacy Services Schedule. Terms not otherwise defined in this Pharmacy Services Schedule shall have the same meaning as such term is otherwise defined in the Agreement.

**Authorized Generics** are Prescription Drugs produced by brand pharmaceutical companies and marketed under a private label, at Generic Drug prices. Authorized Generics are identical to their Brand Drug counterpart in both active and inactive ingredients.

**Average Wholesale Price (AWP)** shall mean the benchmark price of a prescription drug based on the actual 11-digit National Drug Code ("NDC") for the product and package size on the date dispensed to a member as established and reported by Medi-Span or by another nationally recognized pricing source selected by PBM in its sole discretion.

**Brand MAC** is a multi-source Brand Drug that is included on the Maximum Allowable Cost ("MAC") list and paid at the MAC cost basis.

**Branded Generic Claims** are multi-source Brand Drugs that were billed to the Employer at the Generic Drug cost.

**Brand Name Prescription Drug** or **Brand Drug** is a Prescription Drug product that is not a Generic Drug.

**Compound Drug** is a mixture of two or more ingredients when at least one of the ingredients in the preparation is an FDA-approved Prescription Drug, excluding the addition of only water or flavoring to any preparation.

**Covered Prescription Services** means a Covered Service that is Prescription Drugs or other pharmaceutical products, services or supplies dispensed by a pharmacy to a Member for which coverage is provided in accordance with the Member's Benefits Booklet.

**Dispense As Written Claims With Code 1** are Claims where a Brand Drug was dispensed when a Generic Drug is available, because substitution was not prescribed by the Provider.

**Dispense As Written Claims With Code 2** are Claims where a Brand Drug was dispensed when a Generic Drug is available, because the Member requested the Brand Drug.

**Dispense As Written Claims With Code 3** are Claims where a Brand Drug was dispensed when a Generic Drug is available, because the pharmacist selected the Brand Drug.

**Dispense As Written Claims With Code 4** are Claims where a Brand Drug was dispensed when a Generic Drug exists, because the Generic Drug was not in stock.

**Dispense As Written Claims With Code 5** are Claims where a Brand Drug was dispensed when a Generic Drug is available, because the pharmacy dispensed the Brand Drug at the Generic Drug cost (also known as "House Generic Claims").

**Dispense As Written Claims With Code 6** are Claims where a Brand Drug was dispensed when a Generic Drug is available, because of an override.

**Dispense As Written Claims With Code 7** are Claims where a Brand Drug was dispensed when a Generic Drug is available, because the Brand Drug is mandated by state and federal laws and regulations.

**Dispense As Written Claims With Code 8** are Claims where a Brand Drug was dispensed when a Generic Drug exists, because the Generic Drug is not available in the marketplace.

**Dispense As Written Claims With Code 9** are Claims where a Brand Drug was dispensed when a Generic Drug is available, because of other non-specified reason.

**Dispense As Written Claims** are Claims where a Brand Drug was dispensed when a Generic Drug exists and is available.

**Drug Rebates** as referenced herein shall include Medical Drug Rebates and/or Prescription Drug Rebates.

**Generic Prescription Drug** or **Generic Drug** is a Prescription Drug, whether identified by its chemical, proprietary, or non-proprietary name that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.

**Government Reimbursement Claims** are Claims submitted by any state, person or entity acting on behalf of a state under Medicaid or similar federal or state government health care programs for which Employer is deemed to be the primary payer as defined by applicable federal or state laws.

**Medical Drug Rebates** are rebates Anthem and/or PBM receives directly from pharmaceutical manufacturers for Claims for Prescription Drugs administered by Anthem and covered under the medical benefit portion of the Plan(s).

**Most Favored Nations Limitations** are government restrictions that preclude pharmacies from making pricing agreements with PBMs or others that are more favorable than those afforded to state-run programs, such as Medicaid.

**Network Pharmacy** or **Network Pharmacies** are a network of pharmacies that have entered into contractual arrangements with PBM under which such pharmacies agree to provide Covered Prescription Services to Members and accept negotiated fees for such services.

**Pharmacy Benefit Plan** means that portion of the Benefits Booklet that describes Covered Prescription Services that is administered by PBM. Pharmacy Benefit Plan coverage includes any deductible or co-insurance provided for under the Covered Prescription Services.

**Powder Claims** are Claims for drugs where the dosage form, as identified by Medispan database or other nationally recognized pricing source selected by PBM in its sole discretion from time to time, is powder.

**Prescription Drug.** Insulin and those drugs and drug compounds that are included in the U.S. Pharmacopoeia and that are required to be dispensed pursuant to a prescription or that are otherwise included on PBM's formulary (e.g., certain over-the-counter drugs).

**Prescription Drug Claims.** Notwithstanding the definition of Paid Claim as set forth in Article 1 of the Agreement, Prescription Drug Claims shall mean an amount that PBM invoices Employer for Prescription Drugs dispensed to Members by pharmacies. PBM's invoice shall be included as part of the invoice Anthem bills for other Paid Claims, as further set forth in the Agreement.

**Prescription Drug Rebates** are rebates collected by PBM directly or indirectly from pharmaceutical manufacturers for Claims for Prescription Drugs administered by PBM and attributable to the pharmacy benefit portion of the Plan(s).

**Secondary Claims** are Claims where PBM is the secondary payer due to coordination of benefits (COB) with one or more other payers.

**Single Source Generics** are those Generic Drugs that are provided by three or fewer Pharmaceutical Manufacturers as defined at the GPI14 level or such Generic Drugs that are in the market with supply limitations or competitive restrictions.

**Specialty Drugs** are drugs dispensed from a Specialty Service Pharmacy and/or high-cost, injected, infused, oral, or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty Drugs may have special handling, storage, and shipping requirements, such as temperature control. Specialty Drugs may require nursing services or special programs to encourage patient compliance.

**Specialty Service Pharmacy** is the PBM-owned or contracted specialty pharmacy that primarily dispenses Specialty Drugs, outside of the retail pharmacy Network and home delivery pharmacy.

**Usual and Customary (U&C) Charge** is the amount a cash paying customer pays a pharmacy for a Prescription Drug. PBM shall require Network Pharmacies to submit the Usual and Customary Charges with all Claim submissions.

#### B. Obligations of PBM.

In addition to the services provided by Anthem under Article 2 of this Agreement, and if applicable to the Pharmacy Benefit Plan and as indicated in Exhibit B, PBM will provide the following pharmacy benefit management administrative and support services (the "Pharmacy Services"):

##### 1. **Network Pharmacy Services.**

- a. PBM shall offer Employer access to a network of pharmacies that have entered into contractual arrangements with PBM or its Vendors under which such pharmacies agree to provide pharmacy services to Members and accept negotiated fees for such services ("Network Pharmacies"). PBM shall determine, in its sole discretion, which pharmacies shall be Network Pharmacies, and the composition of Network Pharmacies may change from time to time.
- b. PBM shall arrange for the dispensing of covered Prescription Drugs to Members through one or more networks of Network Pharmacies. If a Member obtains a covered Prescription Drug from a pharmacy that is not in the network, the Member shall be responsible for the total cost of the covered Prescription Drug. PBM's network will provide Members adequate access to the covered Prescription Drugs at the Network Pharmacies. Employer acknowledges that the availability of Prescription Drugs is subject to market conditions and that PBM cannot, and does not, assure the availability of any Prescription Drug from a Network Pharmacy.
- c. PBM and/or its Vendors shall perform periodic desktop and onsite audits of Network Pharmacies to ensure compliance with billing requirements as well as other terms and conditions of the Network Pharmacy agreements. PBM will pay Employer, or apply as a credit to invoices, the amounts PBM recovers from these audits. Employer will be financially responsible for all expenses incurred in connection with audits of Network Pharmacies requested by Employer that are not required by applicable law.
- d. Pursuant to the terms of the contract between PBM and Network Pharmacy, no Network Pharmacy shall charge, collect a deposit from, or have any recourse against a Member for the covered Prescription Drugs other than applicable cost shares, including in the event of breach of the Agreement and/or this Pharmacy Services Schedule by Employer or insolvency of Employer. This provision shall survive the termination of the Agreement and/or this Pharmacy Services Schedule for any covered Prescription Drug provided to a Member prior to such termination.
- e. PBM shall offer Employer a home delivery pharmacy program through which Members may receive home delivery covered Prescription Services. The home delivery pharmacy shall dispense Covered Prescription Drugs upon receipt from a Member of (i) a valid new or refill prescription order and (ii) applicable cost share. The covered Prescription Drug shall be mailed to the Member's address set forth in the eligibility file, or as appearing on the face of the prescription, so long as such address is within the United States.

Additional fees for express mail, shipping or handling may be charged to Members. PBM may suspend such services to a Member if Member fails to remit any applicable cost share due.

- f. PBM shall offer Employer a specialty pharmacy program through which Members may receive specialty pharmacy drug services. PBM shall provide all necessary information and forms to Members to obtain these specialty Prescription Drug services.
- g. PBM shall operate a toll-free call center to respond to inquiries from Network Pharmacies regarding Pharmacy Services provided by PBM provided pursuant to this Pharmacy Services Schedule, including but not limited to technical and claims processing issues and Member eligibility verification ("Pharmacy Help Desk"). The Pharmacy Help Desk shall be available 24 hours a day, 7 days a week.

## 2. Drug Formularies.

- a. PBM will furnish and maintain a drug formulary for use with the Pharmacy Benefit Plan, and PBM shall periodically review and update its formulary. Employer shall adopt such formulary as part of the design of the Pharmacy Benefit Plan. The drug formulary will be made available to Members on PBM's web site and upon request may be provided to Employer in a mutually acceptable format for Employer's distribution to Members.
- b. PBM has placed certain Prescription Drugs on formularies that are developed through a process involving two committees, the Pharmacy and Therapeutics Committee ("P&T") and the Value Assessment Committee ("VAC"). The P&T examines the safety and efficacy of a Prescription Drug in comparison to similar drugs within a therapeutic class or used to treat a particular condition. The VAC examines member impact, provider impact, economics, law and regulations, and market dynamics as it determines tiering and utilization management edit placement of Prescription Drugs on the formularies in a manner consistent with the clinical determinations of the P&T.
- c. PBM will notify Members of any removal of a covered Prescription Drug from formularies in accordance with applicable laws.
- d. In the event a Member or Provider believes that a Prescription Drug or supply not included on a formulary is medically necessary to treat the Member's individual condition, the Member or Provider may request a coverage exception. In the coverage exception process, PBM will consider a variety of factors that include, but are not limited to, Prescription Drugs previously tried and failed by the Member to treat a particular diagnosis or condition, whether the Member is clinically stable on the Prescription Drug, and/or whether switching to a covered Prescription Drug would result in a clinically significant adverse reaction or other harm to the Member.

## 3. Claims Processing Services.

- a. PBM shall perform administrative services for Employer, including but not limited to, processing Claims with a Claims Incurred Date indicated in Section 1 of Exhibit A for Covered Prescription Services in accordance with the Pharmacy Benefit Plan. PBM will pay, on Employer's behalf, only Claims that are: (1) timely submitted by Network Pharmacies through PBM's point-of-sale service system; and (2) properly submitted by Members as requests for reimbursement for Covered Prescription Services. Employer may request PBM, on an exception basis, to process and pay Claims that were denied by PBM or take other actions with respect to the Pharmacy Benefit Plan that are not specifically set forth in this Agreement or the Benefits Booklet. PBM may honor such requests subject to system override capability and Employer paying a processing fee that has been mutually agreed to by the Parties.
- b. PBM will implement certain administrative overrides to authorize the dispensing of Prescription Drugs in response to certain requests that include but are not limited to requests for lost/stolen drugs and vacation supplies.
- c. PBM shall disburse to Member or Network Pharmacies payments that it determines to be due according to the provisions of the Pharmacy Benefit Plan.
- d. PBM shall provide notice in writing when a Member submitted Claim has been denied or a prior authorization request has been denied which notice shall set forth the reasons for the denial and the right to a full and fair review of the denial under the terms of the Pharmacy Benefit Plan and shall otherwise satisfy applicable law governing the notice of a denied Claim.

#### 4. **Utilization and Clinical Management Programs.**

- a. PBM will provide a concurrent drug utilization program that assists pharmacies in identifying potential drug interactions, incorrect drug dosage, and inappropriate drug use and misuse. The program utilizes real-time Member health and safety protocols designed to monitor and screen each claim against the Member's Prescription Drug profile and is designed to help promote appropriate Prescription Drug use and help prevent adverse Member reactions. PBM shall make available to prescribing Providers, subject to such prescribing Providers' system capabilities, electronic access to Member eligibility; Prescription Drug Formulary status; Member medication history; a listing of Formulary alternative Prescription Drugs; and applicable cost share.
- b. PBM shall offer additional programs to help ensure clinically appropriate use of Prescription Drugs, and effectively manage the cost of care that may include but not be limited to drug edits (i.e. prior authorization, step therapy, quantity limits, and dose optimization), enhanced fraud waste and abuse program, and medication review. Employer shall pay fees for the programs selected by Employer as set forth on Exhibit A. Employer shall abide by all applicable policies and procedures of the programs selected that may require Employer to provide requested information prior to PBM initiating the service.

#### 5. **General Provisions.**

- a. PBM shall assist Employer in determining whether its Prescription Drug benefit constitutes "creditable prescription drug coverage" as that term is used under the Medicare Part D laws (specifically, 42 C.F.R. 423.56). Unless otherwise agreed to by the Parties, Employer shall be solely responsible for communicating with Members regarding creditable prescription drug coverage matters.
- b. PBM shall make available a toll-free number staffed by adequately trained personnel to address Member questions.
- c. PBM will provide Employer with PBM's standard management and utilization reporting package in connection with the Pharmacy Services provided pursuant to this Pharmacy Services Schedule. At Employer's expense, PBM may prepare and provide custom and ad hoc reports within an agreed-upon time and format, at the rate set forth in Schedule A of the Agreement and/or Exhibit A of this Pharmacy Services Schedule, as applicable.
- d. PBM will provide Pharmacy Services in accordance with the Pharmacy Benefit Plan and the Plan document(s) adopted by Employer. The Pharmacy Services shall be procedural only and shall be performed by PBM within the framework of policies, interpretations, rules, practices, and procedures made, established, and provided in writing to PBM by Employer.
- e. PBM will maintain all licenses, permits, certifications, registrations, and other regulatory approvals required by law necessary for the performance of PBM's obligations pursuant to this Pharmacy Services Schedule.
- f. PBM will maintain at least one of the following accreditations during the term of the Agreement and this Pharmacy Services Schedule: (a) National Committee for Quality Assurance ("NCQA") certification; (b) Utilization Review Accreditation Commission ("URAC") Drug Utilization Management accreditation; and/or (c) such other NCQA certifications and URAC accreditations applicable to the Pharmacy Services provided hereunder.

#### C. **Obligations of Employer.** To the extent not already provided under Article 3 of this Agreement, Employer shall:

1. Provide PBM with timely, accurate and complete information necessary for PBM to provide the Pharmacy Services. PBM shall be under no obligation to verify the accuracy and completeness of information provided to it by Employer.
2. Provide accurate, timely, complete, and ongoing Member eligibility information to PBM using PBM's prescribed format and methods. Such information shall include, but shall not be limited to, the number and names of Members eligible for and covered under the Pharmacy Benefit Plan and any other information determined by PBM to be necessary to provide Pharmacy Services. PBM will load Member eligibility data no later than three business days after receipt from Employer. PBM will be entitled to rely on the accuracy and completeness of



the Member eligibility data from Employer. Employer shall be solely responsible for any errors in Member eligibility data that Employer provides to PBM.

**D. Drug Rebate Management.**

1. During any Agreement Period, Employer shall not contract, directly or indirectly through a third party, with a manufacturer or any other third party for rebates, discounts, or other financial incentives on claims that are eligible for Prescription Drug Rebates under this Agreement. In the event that PBM determines such violation of this paragraph, Employer shall be deemed ineligible to earn Prescription Drug Rebates, the Drug Rebate Program will be suspended, and Employer shall be required to reimburse PBM for any Prescription Drug Rebates that were previously earned. If Employer fails to reimburse PBM for such Prescription Drug Rebates within 10 business days of PBM's request, PBM shall have the right to recover said amounts by offsetting such amounts against any amounts PBM owes Employer under this Agreement or any other agreement between Employer and PBM. Additionally, PBM may renegotiate the guarantees and/or any pricing terms of the Agreement.
2. Employer acknowledges and agrees that Prescription Drug Rebate amounts are subject to change for reasons including but not limited to:
  - a. Prescription Drug Rebate eligibility is modified under an agreement between PBM and/or its Vendor and a manufacturer;
  - b. laws and regulations affecting the distribution or the amount of Prescription Drug Rebates available or payable under such laws and regulations; or
  - c. any action(s) or inaction(s) by manufacturer that impacts the availability or amount of Prescription Drug Rebate earned, that includes, but is not limited to, manufacturer's discontinuation of the covered Prescription Drugs.

If any change set forth in (a) - (c) above occurs, PBM may provide written notice to Employer of such change as soon as reasonably practicable. In such event, PBM shall notify Employer and revise or eliminate such payment as of the effective date of the reduction or elimination of the Drug Rebate payment. Such reduction or elimination of the Drug Rebate payment shall result in either a change in the Base Administrative Services Fee as described in Article 18(c) of the Agreement or a change in the percentage of Prescription Drug Rebates retained by PBM.

3. PBM will use reasonable efforts to negotiate and collect Prescription Drug Rebates from manufacturers. PBM shall not be required to institute litigation to negotiate and collect Prescription Drug Rebates from manufacturers. If PBM or its designee does elect to bring suit to recover Prescription Drug Rebates from manufacturers, PBM shall be entitled to deduct all reasonable attorney's fees and other expenses incurred in such litigation prior to payment of the Prescription Drug Rebates to Employer. Neither Party shall be responsible to the other Party, its affiliates, directors, employees, agents, successors, or permitted assigns for any claim arising from: (i) any failure by a manufacturer to pay any Prescription Drug Rebates; (ii) any breach of an agreement relating to the transactions contemplated by or otherwise relating to this Agreement by any manufacturer; or (iii) any negligence or misconduct of any manufacturer.
4. In the event that PBM, its Vendor, and/or manufacturer identifies through audit or other means that Employer has received an overpayment or an erroneous Drug Rebate payment, Employer shall immediately refund such amounts. If Employer fails to do so, PBM shall have the right to recover said amounts by offsetting such amounts against any amounts PBM owes Employer under this Agreement or any other agreement between Employer and PBM.
5. Prescription Drug Rebates paid pursuant to the Agreement and Exhibit A of the Pharmacy Services Schedule are intended to be treated as "discounts" pursuant to the Federal Anti-Kickback Statute set forth at 42 C.F.R. § 1320a-7b and implementing regulations.
6. PBM shall continue to provide Employer its share of the Prescription Drug Rebates under this provision until the termination of this Agreement and any applicable Claims Runout Period. PBM shall provide a final report of the Prescription Drug Rebates received attributable to Employer's Plan after the end of the Claims Runout Period. Any Prescription Drug Rebates received by PBM after the end of the Claims Runout Period shall be retained by PBM.



7. Employer acknowledges and agrees that no Prescription Drug Rebates shall be paid pursuant to Exhibit A unless and until this Pharmacy Benefit Services Schedule is fully executed.

**E. Pharmacy Base Administrative Services Fees and Expenses**

1. Employer agrees to pay PBM fees for the Pharmacy Services as set forth on Exhibit A.
2. PBM's fees for the Pharmacy Services may be renegotiated in the event of substantial changes that would increase or decrease the obligations or costs of providing the Pharmacy Services, including but not limited to changes in the Pharmacy Benefit Plan, legislative changes, or postal rate changes. In addition to other rights set forth in Article 18(c) of the Agreement, PBM shall have the right to change the Pharmacy Base Administrative Services Fees or other fees provided in Exhibit A if: (a) PBM is no longer the sole provider of the Covered Prescription Services contemplated in this Pharmacy Services Schedule; (b) Employer implements an on-site pharmacy; or (c) a change in applicable law occurs resulting in an increase in the cost or amount of Covered Prescription Services under this Agreement. PBM shall provide notice to Employer of the change in the Pharmacy Base Administrative Services Fees at least 30 days prior to the implementation date of such change. Any change in the Pharmacy Base Administrative Services Fees will be effective as of the date the change occurs, even if that date is retroactive. If such change is unacceptable to Employer, either Party shall have the right to terminate this Pharmacy Services Schedule by giving written notice of termination to the other Party before the effective date of the change. If Employer accepts the proposed Pharmacy Base Administrative Services Fees, PBM shall provide a revised Exhibit A, and, if applicable, Schedule A, that will then become part of this Agreement without the necessity of securing Employer's signature on the Exhibit and, if applicable, Schedule.
3. If changes in the Pharmacy Benefit Plan are incompatible with existing systems and procedures and require PBM or its subcontractor to perform additional programming, reports, or services, such additional activities will be performed at the expense of Employer, if agreed to by PBM.
4. Employer shall be responsible for out-of-pocket production costs, travel expenses, and banking expenses incurred by PBM in carrying out implementation activities at the request of Employer.
5. PBM shall not provide or be responsible for the expenses or costs of services furnished by attorneys, actuaries, certified public accountants, investment counselors, or investment analysts, or for similar services performed for Employer. PBM shall not be authorized to engage such services or incur any expense or cost therefore without the written consent of Employer. In the event that such services are engaged by PBM at the written request of Employer, Employer shall be responsible for all costs and expense thereof, that shall be separately billed by the provider of the services or by PBM as incurred.
6. Employer agrees to pay PBM fees for Claims Runout Services described in Section 5 of Exhibit A of the Pharmacy Services Schedule.

**F. Audits.**

1. Unless otherwise provided for in this Section F of the Pharmacy Services Schedule, the parties acknowledge and agree that the Claims audit provisions set forth in Article 12 of the Agreement shall apply. However, in the event of any conflict between the Claims audit provisions in Article 12 of the Agreement and this Pharmacy Services Schedule, the terms and conditions of this Pharmacy Services Schedule shall govern with respect to the provision of Pharmacy Services.
2. Employer, must provide at least 60 days prior written notice to PBM of its intent to conduct an audit of PBM's performance under this Pharmacy Services Schedule to ensure compliance with the Agreement and applicable laws. The scope of an audit including time, place, type and duration of all audits must be reasonable, agreed to by PBM, and in accordance with PBM's audit procedures and guidelines. Onsite audits and access to claims processing systems will not be permitted.
3. Any Employer requests for a third party auditor to audit will constitute Employer's direction and authorization to PBM to disclose Employer-specific information, including Member information and PHI, to Employer's auditor. PBM will provide Employer's auditor with access to all applicable Employer-specific information reasonably necessary to determine the accuracy of Claims payments and verify PBM's performance under this Pharmacy Services Schedule, subject to PBM's third party confidentiality obligations; provided, however, any other documentation requested during the course of an audit not in the audit scope or necessary for the audit, will be provided at PBM's discretion.

4. Employer shall not be permitted to audit any contract between PBM, its Vendors, subcontractors, or manufacturers.

G. **Termination.** In addition to the provisions in Article 19 of this Agreement,

1. Either Party may terminate this Pharmacy Services Schedule by giving 90 days notice prior to the date of the termination.
2. This Pharmacy Services Schedule shall terminate on the date the Agreement is terminated unless otherwise agreed to by the Parties. If the Parties agree to continue the Pharmacy Services Schedule after termination, applicable provisions of the Agreement shall remain in effect until a new agreement is reached by the Parties.
3. This Pharmacy Services Schedule shall terminate on the effective date of any governmental body's action that prohibits all activities contemplated under this Pharmacy Services Schedule.
4. Following termination of only this Pharmacy Services Schedule, the remainder of the Agreement shall continue in full force and effect during the Agreement Period. Termination of this Pharmacy Services Schedule will not terminate the rights or obligations of either Party arising out of the period during which this Agreement was in effect.
5. In the event of termination of this Pharmacy Services Schedule, PBM shall not be responsible for notifying Members of such termination or of the procedure to be followed to retain or obtain Plan coverage.
6. Upon notice of termination of this Pharmacy Services Schedule for any reason other than for non-payment of amounts due under this Schedule, the Parties will mutually develop a transition plan that includes but is not limited to: (1) a schedule of transition activities and timelines for completion; (2) a detailed description of the respective roles of PBM and Employer; and (3) such other information and planning as necessary to ensure that the transition takes place according to an agreed upon schedule and with minimum disruption to Members. The transition plan shall be subject to written approval by both Parties.
7. Unless mutually agreed to in writing by the Parties, upon termination of this Pharmacy Services Schedule, Employer shall cease adoption and use of PBM's formulary as part of its Plan and agrees that it shall not copy, distribute, or sell PBM's formulary.

IN WITNESS WHEREOF, the Parties have executed this Schedule to be effective as of the pharmacy Agreement Period.

Owens & Minor, Inc.

HealthKeepers, Inc. and Anthem Health Plans of Virginia,  
Inc. dba Anthem Blue Cross and Blue Shield

By: \_\_\_\_\_

By: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

IngenioRx, Inc.

By: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**EXHIBIT A**  
**PHARMACY BENEFITS ADMINISTRATIVE SERVICES SCHEDULE**  
**TO**  
**ADMINISTRATIVE SERVICES AGREEMENT**  
**WITH**  
**Owens & Minor, Inc.**

This Exhibit A shall govern the Agreement Period from January 1, 2020 through December 31, 2020 and is made part of this Pharmacy Benefits Administrative Services Schedule. This Exhibit is intended to supplement the Agreement between the Parties as it relates to Pharmacy Services only. In the event of an inconsistency between the applicable provisions of this Pharmacy Services Schedule and the Agreement, the terms of this Pharmacy Services Schedule shall govern, but only as they relate to Pharmacy Services. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

**Section 1. Effective Date and Renewal Notice**

This Agreement Period shall be from 12:01 a.m. January 1, 2020 to the end of the day of December 31, 2020.

Paid Claims shall be processed pursuant to the terms of this Pharmacy Services Schedule when incurred and paid as follows:

- Incurred from June 1, 2017 through December 31, 2020 and
- Paid from January 1, 2020 through December 31, 2020.

PBM shall provide any offer to renew this Pharmacy Services Schedule at least 90 days prior to the end of an Agreement Period.

**Section 2. Broker or Consultant Base Compensation**

Not Applicable

**Section 3. Pharmacy Administrative Services Fees**

Change to Administrative Services Fees. The Administrative Services Fees in Section 3 of Schedule A of the Agreement and the Pharmacy Administrative Services Fees in Section 3 of Exhibit A may be changed during the Agreement Period based upon an event in Article 18(c) of the Agreement or Section E(2) of the Pharmacy Services Schedule.

**A. Pharmacy Base Administrative Services Fee**

Pharmacy Base Administrative Services Fee. The Pharmacy Administrative Services Fees shall also include a fee that will be charged monthly for services related to pharmacy benefits management including, but not limited to, pharmacy mail services, clinical services, and customer services. Such fee shall be \$0.00.

**B. Drug Rebate Allocation**

1. PBM and/or its Vendor has negotiated programs with pharmaceutical manufacturers for drug rebates on certain Prescription Drugs dispensed to Members and has arranged for payments of such rebates to be made directly to PBM ("Drug Rebate Programs"). PBM has entered into such Drug Rebate Programs on its behalf and not on behalf of Employer, and therefore retains all rights, title, and interest to any and all actual Prescription Drug Rebates it receives from manufacturers and/or its Vendor. Such Drug Rebate Programs are not based solely on the Prescription Drug utilization of one Employer Plan, but rather are based on the Prescription Drug utilization of all individuals enrolled in PBM managed programs. The Prescription Drug Rebates are conditioned on certain Prescription Drugs being included on the formulary that PBM requires Employer to adopt as part of its Plan. Employer shall be paid or credited a portion or the amount attributable to its actual or estimated value of Prescription Drug Rebates as described in Section 3(B) of Exhibit A.
2. PBM may receive and retain administrative fees directly from pharmaceutical manufacturers. In addition, PBM may receive and retain service fees from pharmaceutical manufacturers for providing services (e.g., Provider and Member education programs that promote clinically appropriate and safe dispensing and

use of Prescription Drugs). For purposes of this Pharmacy Services Schedule, administrative fees and service fees received by PBM shall not be considered Prescription Drug Rebates.

3. Prescription Drug Rebates: PBM will pay to Employer 100% of the Prescription Drug Rebates collected by PBM directly from pharmaceutical manufacturers for claims for Prescription Drugs administered by PBM and attributable to Employer's Plan subject to PBM's timely and actual receipt of payment and accompanying data from pharmaceutical manufacturers. On a quarterly basis, PBM shall credit Employer the Prescription Drug Rebates it has collected. PBM shall have the right to collect from Employer any rebate amount that PBM is required to pay a pharmaceutical manufacturer as a result of a pharmaceutical manufacturer audit or for any other reason.
4. Medical Drug Rebates. PBM shall retain 100% of the Medical Drug Rebates.

C. **Other Fees or Credits**

Fee for Pharmacy Buy-up Options.

- Comprehensive with Specialty: \$1.69 per pharmacy Claim

Fee for Vaccine Administration. PBM shall charge a fee for the administration of vaccines at a retail pharmacy location of \$2.50 per vaccine.

Fee for Medication Review Note. PBM shall charge a fee of \$0.25 per pharmacy Claim for clinical, quality and cost-of-care messages in personalized Member communications.

Fee for Custom Communications. PBM shall charge a fee of \$1.00 per custom communication requested by the Employer.

Fee for Member-Submitted Claims. PBM shall charge a fee of \$1.00 per Claim for each Member-submitted Claim.

PBM Services Early Termination Fee. In consideration of the special pricing arrangements under this Agreement, Employer shall pay PBM an Early Termination Fee, as described below, if Employer terminates the pharmacy portion of the Plan before the end of the Performance Period (as defined in Exhibit C) for any reason other than PBM's failure to comply with a material duty or obligation related to the administration of pharmacy benefits under this Agreement.

The Early Termination Fee shall be calculated by multiplying \$4.80 PSPM by (i) the average monthly Subscriber count for the 6 months immediately prior to termination; multiplied by (ii) the number of months remaining in the Performance Period. Upon termination of the Agreement, 0.00% of unpaid Rebates for services prior to termination will be retained by PBM. If Employer intends to terminate the pharmacy portion of the Plan before the end of the Performance Period, Employer must provide PBM with the required termination notice under Section G of the Pharmacy Services Schedule. In the event Employer terminates the pharmacy portion of the Plan before the end of the Performance Period, the applicable Early Termination Fee will be billed to Employer with the amount due within 30 days of the termination date.

Invoices for Prescription Drug Claims: When PBM invoices Employer for Prescription Drug Claims, the amount billed will reflect pricing that may be greater than the amount that is paid to pharmacies for those Claims (Margin Pricing). The use of Margin Pricing provides some control over price swings that members may otherwise experience when filling prescriptions.

Fee for Ad Hoc Reports. PBM shall provide, on an annual basis, up to 20 hours of time needed to generate custom or ad hoc reports at no additional charge. The charge to Employer beyond 20 hours per year is \$150.00 per hour for time needed to generate custom or ad hoc reports.

**Section 4. Pharmacy Administrative Services Fees and Paid Claims Billing Cycle and Payment Method**

Billing cycles and payment methods are contained in Schedule A.

**Section 5. Claims Runout Services**

**A. Claims Runout Period**

Claims Runout Period shall be for the 12 months following the date of termination of this Pharmacy Services Schedule.

**B. Claims Runout Administrative Services Fee**

Pharmacy:

The fee for Claims Runout Services will be waived. Fees that (i) are associated with Claims processed or reviewed during the Claims Runout Period including without limitation subrogation fees, Claims prepayment analysis fees, recovery fees, network access fees; or (ii) apply to the Pharmacy Services Schedule Period but were not billed during the Pharmacy Services Schedule Period, will be billed and payable during the Claims Runout Period. Payment is due to PBM by the Invoice Due Date.

**Section 6. Other Amendments. The Pharmacy Benefits Administrative Services Schedule is otherwise amended as follows:**

Not applicable

IN WITNESS WHEREOF, the Parties have executed this Exhibit to be effective as of the pharmacy Agreement Period.

Owens & Minor, Inc.

HealthKeepers, Inc. and Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield

By: \_\_\_\_\_

By: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

IngenioRx, Inc.

By: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**EXHIBIT B**  
**PHARMACY BENEFITS ADMINISTRATIVE SERVICES SCHEDULE**  
**TO**  
**ADMINISTRATIVE SERVICES AGREEMENT**  
**WITH**  
**Owens & Minor, Inc.**

This Exhibit B shall govern the Agreement Period from January 1, 2020 through December 31, 2020 and is made part of this Pharmacy Benefits Administrative Services Schedule. This Exhibit is intended to supplement the Agreement between the Parties as it relates to Pharmacy Services only. In the event of an inconsistency between the applicable provisions of this Pharmacy Services Schedule and the Agreement, the terms of this Pharmacy Services Schedule shall govern, but only as they relate to Pharmacy Services. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

The following is a list of services that PBM will provide under this Pharmacy Services Schedule for the Base Administrative Services Fee set forth on Exhibit A. These services will be furnished to Employer in a manner consistent with PBM's standard policies and procedures for self-funded plans. PBM may also offer services to Employer that have an additional fee. If Employer has purchased such services, those services and any additional fees are also set forth on Exhibit A.

**Prescription Benefit Services**

- Home delivery pharmacy
- Specialty Pharmacy Services
  - Prescription eServices
  - Pharmacy locator
  - Online formulary
- Point of sale claims processing
- Home delivery claims processing
- Home delivery call center with toll free number
- Home delivery regular shipping and handling
- Standard management reports
- Ad hoc reports (subject to additional programming charge)
- Concurrent Drug Utilization Review (DUR) programs
- Retrospective DURs
- Administrative override (i.e., vacation, lost, stolen or spilled medications)
- Pharmacy help desk with toll free number
- Audits of pharmacies
- Assistance in determining "creditable prescription drug coverage" under Medicare Part D

**EXHIBIT C**  
**PHARMACY BENEFITS ADMINISTRATIVE SERVICES SCHEDULE**  
**TO**  
**ADMINISTRATIVE SERVICES AGREEMENT**  
**WITH**  
**Owens & Minor, Inc.**

This Exhibit C provides certain guarantees pertaining to PBM's performance under the Agreement between the Parties ("Performance Guarantees") and shall be effective for each year in the period from January 1, 2019 through December 31, 2020 (the "Performance Period"). Descriptions of the terms of each Performance Guarantee applicable to the Parties are set forth in the Attachments (the "Attachments") to this Exhibit C and made a part of this Exhibit C. This Exhibit shall supplement and amend the Pharmacy Benefits Administrative Services Schedule between the Parties. If there are any inconsistencies between the terms of the Agreement and this Exhibit C, the terms of this Exhibit C shall control. If there are any inconsistencies between the terms contained in this Exhibit, and the terms contained in any of the Attachments to this Exhibit C, the terms of the Attachments to this Exhibit C shall control.

**Section 1.      General Conditions**

- A. The Performance Guarantees described in the Attachments to this Exhibit C shall be in effect only for the Performance Period indicated above, unless specifically indicated otherwise in the Attachments. Each Performance Guarantee shall specify a/an:
  1. Allocation. The term Allocation is the percent of total Amount at Risk to each Performance Guarantee.
  2. Amount at Risk. The term Amount at Risk means the amount PBM may pay if it fails to meet the target(s) specified under the Performance Guarantee.
  3. Measurement Period. The term Measurement Period is the period of time under that PBM's performance is measured, that may be the same as or differ from the period of time equal to the Performance Period.
  4. Performance Category. The term Performance Category describes the general type of Performance Guarantee.
  5. Reporting Period. The term Reporting Period refers to how often PBM will report on its performance under a Performance Guarantee.
  6. Service Feature. The term Service Feature is a service standard stipulated and defined to be guaranteed.
- B. PBM shall conduct an analysis of the data necessary to calculate any one of the Performance Guarantees within the timeframes provided in the Attachments to this Exhibit C. In addition, any calculation of Performance Guarantees, reports provided, or analysis performed by PBM shall be based on PBM's then current measurement and calculation methodology, that shall be available to Employer upon request.
- C. Any audits performed by PBM to test compliance with any of the Performance Guarantees shall be based on a statistically valid sample size with a 95% confidence level.
- D. If the Agreement is not executed, PBM shall have no obligation to make payment under these Performance Guarantees.
- E. Unless otherwise specified in the Attachments to this Exhibit C, the measurement of the Performance Guarantee shall be based on data that is maintained and stored by PBM or its Vendors.
- F. If Employer terminates the Agreement or the Pharmacy Services Schedule between the Parties prior to the end of the Performance Period, or if the Agreement or the Pharmacy Services Schedule is terminated for non-payment, then Employer shall forfeit any right to collect any further payments under any outstanding Performance Guarantees, whether such Performance Guarantees are for a prior or current Measurement Period or Performance Period.
- G. PBM reserves the right to make changes to any of the Performance Guarantees provided in the Attachments to this Exhibit C upon the occurrence, in PBM's determination, of either:



1. a change to the Plan benefits or the administration of the Plan initiated by Employer that results in a substantial change in the services to be performed by PBM or the measurement of a Performance Guarantee;
2. an increase or decrease of 10% or more of the number of Members that were enrolled for coverage on the latter of the effective date or renewal date of this Pharmacy Services Schedule.
3. a failure by Employer to implement its responsibilities under the clinical management programs that are part of the Plan;
4. a failure by Employer to adopt the Formulary;
5. a change in the proportionate mix of Employer's retail and home delivery Prescription Drug Claims of more than 10% (including, but not limited to, a change in the overall Members' percentage of usage of retail and mail order pharmacies);
6. a change in pharmacy utilization patterns of more than 10% (including, but not limited to, a change in the overall Members' percentage of usage of Brand Drugs, Generic Drugs, and Specialty Drugs);
7. a change that results in PBM no longer being the exclusive source of Prescription Drug Rebates for Employer's Plan;
8. the determination that Employer has an on-site pharmacy with 340b designation or any such designation where the pharmacy receives upfront pricing discounts from pharmaceutical manufacturers, that was not disclosed or known by PBM as of the effective date of this Attachment to Exhibit C;
9. PBM is no longer the sole administrator for Employer's Prescription Drug Plan;
10. a government action or major change in pharmaceutical industry practices that eliminates or materially reduces the manufacturer Drug Rebate program; or
11. a failure by Employer to maintain the selected Formulary and applicable clinical edits or Employer has excepted Members from application of the selected Formulary and clinical edits that prevent full savings from accruing.

Should there be a change in occurrence as indicated above and these changes negatively impact PBM's ability to meet the Performance Guarantees, PBM shall have the right to modify the Performance Guarantees contained in the Attachments.

- H. For the purposes of calculating compliance with the Performance Guarantees contained in the Attachments to this Exhibit C, if a delay in performance of, or inability to perform, a service underlying any of the Performance Guarantees is due to circumstances that are beyond the control of PBM, or its Vendors, including but not limited to any act of God, civil riot, floods, fire, acts of terrorists, acts of war or power outage, such delayed or non-performed service will not count towards the measurement of the applicable Performance Guarantee.
- I. As determined by PBM, Performance Guarantees may be measured using either aggregated data or Employer-specific Data. The term Employer-specific Data means the data associated with Employer's Plan that has not been aggregated with other Employer data. Performance Guarantees will specify if Employer-specific Data shall be used for purposes of measuring performance under the Performance Guarantee.
- J. If any Performance Guarantees are tied to a particular program and its components, such Performance Guarantees are only valid if Employer participates in the program and its components for the entirety of the Measurement Period associated with the Performance Guarantee.
- K. Employer acknowledges and agrees that each Performance Guarantee will be measured based on the Measurement Period as described in the Attachments to this Exhibit C and prorated to account for Employer specific Effective or renewal dates when measured using aggregated data. The Performance Guarantee will begin on the Employer Effective Date. However, if the Employer terminates the Pharmacy Benefits Schedule before the end of a Measurement Period, the Performance Guarantee measured will be based on the entire Measurement Period during which the termination occurred.

## **Section 2. Payment**

- A. If PBM fails to meet any of the obligations specifically described in a Performance Guarantee described in the Attachments to this Exhibit C, PBM shall pay Employer the amount set forth in the Section describing the Performance Guarantee. Payment shall be in the form of a credit on Employer's invoice for Administrative Services Fees that will occur annually unless otherwise stated in the Performance Guarantee.
- B. Notwithstanding the above, PBM has the right to offset any amounts owed to Employer under any of the Performance Guarantees contained in the Attachments to this Exhibit C against any amounts owed by Employer to PBM under: (1) any Performance Guarantees contained in the Attachments to this Exhibit C; or (2) the Agreement.
- C. Notwithstanding the foregoing, PBM's obligation to make payment under the Performance Guarantees is conditioned upon Employer's timely performance of its obligations provided in the Agreement and the Pharmacy Schedule, in this Exhibit C and the Attachments, including providing PBM with the information or data required by PBM in the Attachments. PBM shall not be obligated to make payment under a Performance Guarantee if Employer or Employer's vendor's action or inaction adversely impacts PBM's ability to meet any of its obligations provided in the Attachments related to such Performance Guarantee, that expressly includes but is not limited to Employer or its vendor's failure to timely provide PBM with accurate and complete data or information in the form and format expressly required by PBM.
- D. Where the Amount at Risk for a Performance Guarantee is on a percentage of a Per Subscriber Per Month (PSPM) fee basis, the Guarantee will be calculated by multiplying the PSPM amount by the actual annual enrollment during the Measurement Period.
- E. PBM shall reconcile the pricing Performance Guarantees described in Attachment #1 to Exhibit C on an annual basis, calculated in accordance with Section 4 of this Exhibit C. The reconciliation for each year of the Performance Period will be submitted to Employer within 90 days after the end of the Measurement Period and any resulting value shortfall shall be paid by PBM to Employer within 30 days following submission of the reconciliation report.
- F. PBM shall pass through rebate amounts collected by PBM as described in Attachment #1 to Exhibit C on a quarterly basis in accordance with Section 3 of this Exhibit C to Employer within 180 days after the end of the calendar quarter. PBM will pass through additional collections from prior quarters in subsequent quarterly disbursements. PBM shall reconcile the Performance Guarantees for each rebate Performance Guarantee described in Attachment #1 to Exhibit C on an annual basis, calculated in accordance with Section 3 of this Exhibit C. The reconciliation for each Measurement Period will be submitted to Employer within 10 months following the end of the Measurement Period and any resulting value shortfall shall be paid by PBM to Employer within 30 days following the reconciliation.

## **Section 3. Prescription Drug Rebate Performance Guarantees**

- A. Any payment due to Employer under a rebate Performance Guarantee will not be offset by favorable results achieved in any other rebate Performance Guarantee. Any payment due to Employer under this Performance Guarantee will not be offset by favorable results achieved in the Prescription Drug pricing Performance Guarantee nor will it be offset by favorable results achieved in the Generic Dispensing Rate Performance Guarantee.
- B. This Performance Guarantee will be determined by comparing the total Prescription Drug Rebates Performance Guarantee to the Prescription Drug Rebates credited to the Employer pursuant to the Pharmacy Services Schedule and Section 3(B) of Exhibit A. If the total Prescription Drug Rebates Performance Guarantee exceeds the Prescription Drug Rebates credited to the Employer, PBM will credit Employer the difference.
- C. For purposes of these Performance Guarantees, the following Claims will not be included in the calculation:
  - Medicare Part D;
  - 340b pharmacy;
  - Vaccines;
  - Prescriptions filled through the Employer's on-site pharmacy;
  - Claims paid on the basis of U&C charges;
  - Compound Drugs;

- Over-the-counter drugs;
- Dispense As Written Claims with code 4;
- Dispense As Written Claims with code 5 (House Generic Claims);
- Dispense As Written Claims with code 6;
- Dispense As Written Claims with code 9;
- Government Reimbursement Claims.
- Out-of-Network Claims;

#### **Section 4. Prescription Drug Pricing Performance Guarantees**

- A To determine any payment due to Employer under these Prescription Drug pricing Performance Guarantees, each Performance Guarantee is calculated based on the Prescription Drugs that were paid during the Measurement Period for:

- retail pharmacy,
- Home delivery,
- Retail 90,
- Specialty Drugs,

(each such subset of Paid Claims is referred to as a "Pricing Guarantee Category").

Each guarantee within a Pricing Guarantee Category is then compared to the sum of appropriate portion of the Paid Claims for Prescription Drugs plus any Member cost shares associated with each Performance Guarantee within that Pricing Guarantee Category. Paid Claims for Prescription Drugs include Ingredient Costs plus Dispensing Fees. Therefore, Paid Claims for Prescription Drugs dispensed by a retail pharmacy are separated into Brand and Generic Ingredient Costs and Brand and Generic Dispensing Fees. These Ingredient Costs and Dispensing Fees are compared against each identified Performance Guarantee provided in this Pharmacy Services Schedule to determine if the Performance Guarantee is met.

- B Any payment due to Employer under any Performance Guarantee within a pricing guarantee Performance Category will not be offset by: (i) favorable results achieved in any other Performance Guarantee within that same pricing guarantee Performance Category, (ii) overall favorable results for a pricing guarantee Performance Category; or (iii) any rebate guarantee or Generic Dispensing Rate guarantee.

- C The following conditions apply to this Performance Guarantee:

- 1 This Performance Guarantee applies to Claims submitted by Network Providers applicable to Employer's Plan.
- 2 The following Claims will be excluded from this Performance Guarantee:
  - Medicare Part D;
  - 340b pharmacy;
  - Vaccines;
  - Prescriptions filled through the Employer's on-site pharmacy;
3. Single Source Generics will be included in the Brand Discount and Brand Dispensing Fee Performance Guarantees and not in the Generic Discount and Generic Dispensing Fee Performance Guarantees.
4. Drugs identified at the time the prescription is filled as Dispense As Written Claims with code 3 will be included in the Generic Discount and Generic Dispensing Fee Performance Guarantees.
5. Drugs identified at the time the prescription is filled as Dispense As Written Claims with code 4 will be included in the Generic Discount and Generic Dispensing Fee Performance Guarantees.
6. Drugs identified at the time the prescription is filled as Dispense As Written Claims with code 5 will be included in the Generic Discount and Generic Dispensing Fee Performance Guarantees.
7. Drugs identified at the time the prescription is filled as Dispense As Written Claims with code 6 will be included in the Generic Discount and Generic Dispensing Fee Performance Guarantees.

8. Drugs identified at the time the prescription is filled as Dispense As Written Claims with code 9 will be included in the Generic Discount and Generic Dispensing Fee Performance Guarantees.
9. This Guarantee applies only as long as there are at least 78,001 Annualized Adjusted Prescription Drug Claims.

- D. In the event that there are court or government imposed or industry wide or pricing source initiated changes in the AWP reporting source or source changes in the methodology used for calculating AWP, including, without limitation, changes in the mark-up factor used in calculating AWP (collectively, the "AWP Changes"), the terms of any financial relationship between the Parties that relate to AWP will be modified by PBM such that the value of AWP for the purpose of such relationship(s) will have the same economic equivalence in the aggregate to the value used by the Parties prior to the AWP Change. The intent of this provision is to preserve the relative economics of both Parties for such financial relationships based upon AWP to that which existed immediately prior to the AWP Change.

In the event that the AWP pricing benchmark used by PBM's PBM hereunder is replaced with another benchmark calculation, PBM may switch to such new pricing benchmark. If a change to pricing guarantees is deemed necessary PBM will provide written notice of new pricing terms at least 30 days before the effective date of the change.

## **Section 5. Generic Dispensing Rate Guarantees**

- A. Generic Dispensing Rate is defined as the total number of Generic Prescription Drug Claims received by PBM divided by the total number of Prescription Drug Claims received by PBM.
- B. Any penalty owed for this Performance Guarantee will be calculated as follows: PBM shall determine the total Ingredient Cost for Generic Prescription Drugs and Brand Name Prescription Drugs by adding the Ingredient Cost for Brand Name Prescription Drugs and the Ingredient Cost for Generic Prescription Drugs. PBM shall determine the total number of Claims received by PBM for Brand Name Prescription Drugs and Generic Prescription Drugs. PBM shall determine the average cost per Generic Prescription Drug by dividing the total Ingredient Cost for Generic Prescription Drugs by the total number of Generic Prescription Drug Claims received by PBM. PBM shall determine the average cost per Brand Name Prescription Drug by dividing the total brand Ingredient Cost by the total number of Brand Name Prescription Drug Claims received by PBM.
- C. PBM shall then recalculate the total Ingredient Cost for Brand Name Prescription Drugs and Generic Prescription Drugs by multiplying the target guarantee percentages separately by the total number of Brand Name Prescription Drugs and Generic Prescription Drug claims received by PBM that is then multiplied separately by the average Ingredient Cost per Brand Name Prescription Drug and the average Ingredient Cost per Generic Prescription Drug. The resulting difference in Ingredient Cost and the recalculated total Ingredient Cost is the penalty up to a maximum payout of \$180,000.00. Any payment due to Employer under this Performance Guarantee will not be offset by any favorable results achieved in the Prescription Drug Pricing Performance Guarantee nor will it be offset by favorable results achieved in the Minimum Drug Rebates Performance Guarantee. Any payment due to Employer under these Generic Dispensing Rate Performance Guarantees will not be offset by favorable results achieved in any other Generic Dispensing Rate Performance Guarantees.
- D. The following conditions apply to this Performance Guarantee:
  1. Employer must have a 3-tier benefit structure for Prescription Drugs, and a minimum \$25 copay differential between Generic Prescription Drugs and Preferred Brand Name Prescription Drugs, and a \$15 copay differential between Preferred Brand Name Prescription Drugs and Non-Preferred Brand Name Prescription Drugs.
  2. Employer must implement generic management clinical programs as recommended by PBM.
  3. Employer cannot make any benefit changes that result in disadvantaging the use of Generic Prescription Drugs.

- 4 Employer must include Member pay difference logic for Brand Name Prescription Drugs that offer an AB rated equivalent Generic Prescription Drug.
- E. The following Claims will be excluded from this Performance Guarantee:
- Prescriptions filled through the Employer's on-site pharmacy;

**ATTACHMENT 1 TO EXHIBIT C  
Performance Guarantees**

**TO ADMINISTRATIVE SERVICES AGREEMENT  
WITH  
Employer Legal Name**

**Pharmacy Performance Guarantees**

This Attachment is made part of Exhibit C and will be effective for the Performance Period from 1/1/2019 through 12/31/2020. This Attachment is intended to supplement and amend the Agreement between the Parties. The Measurement Period for these Performance Guarantees will be annual, unless otherwise specified herein. These Performance Guarantees are guaranteed upon offer and acceptance of renewal of the medical portion of the Agreement.

<b>Pharmacy Performance Guarantee</b>	<b>Measurement and Reporting Period</b>
<b>Prescription Drug Rebate Guarantees</b>	<b><u>Measurement Period</u></b> Annual
<b><u>Minimum Drug Rebates:</u></b>	
(a) The Prescription Drug Rebates Employer receives from PBM will not be less than the following amounts ("Total Drug Rebates Guarantee"):	<b><u>Reporting Period</u></b> Annual

**OPEN FORMULARY**

**BRAND NAME PRESCRIPTION DRUGS**

(1) An amount equal to the sum of N/A (YR1) N/A (YR2) per Paid Claim for Brand Name Prescription Drugs dispensed at **retail** pharmacy Network Providers; plus

(2) An amount equal to the sum of N/A (YR1) N/A (YR2) per Paid Claim for Brand Name Prescription Drugs dispensed at **home delivery** Network Providers.

**Prescription Drug Pricing Guarantees**

**Prescription Drug Pricing:**

(a) The Prescription Drug Pricing Guarantees for Ingredient Cost Discount and Dispensing Fees will be the amounts listed under the following Pricing Guarantee Categories:

**Measurement Period**  
Annual  
**Reporting Period**  
Annual

**NATIONAL RETAIL PHARMACY NETWORK**

**RETAIL PHARMACY NETWORK PROVIDERS**

The guarantees for retail pharmacy Network Providers will be the following amounts:

1. Brand Discount: AWP minus 17.75% (YR1) 18.00% (YR2)
2. Brand Dispensing Fee: \$0.55 (YR1) \$0.55 (YR2)
3. Generic Discount: AWP minus 82.00% (YR1) 82.25% (YR2)
4. Generic Dispensing Fee: \$0.55 (YR1) \$0.55 (YR2)
5. Overall Specialty Drugs Discount: AWP minus 17.00% (YR1) 17.25% (YR2)
6. Overall Specialty Drugs Dispensing Fee: \$0.55 (YR1) \$0.55 (YR2)

**RETAIL 90 PHARMACY NETWORK PROVIDERS**

The guarantees for retail pharmacy RETAIL 90 Network Providers dispensing 84-90 day supplies will be the following amounts:

1. Brand Discount: AWP minus 21.00% (YR1) 21.25% (YR2)
2. Generic Discount: AWP minus 83.00% (YR1) 83.25% (YR2)

**Pharmacy Performance Guarantee****MAIL/HOME DELIVERY OPTIONS****HOME DELIVERY PHARMACY**

The guarantees for home delivery will be the following amounts:

1. Brand Discount: AWP minus 25.00% (YR1) 25.25% (YR2)
2. Brand Dispensing Fee: \$0.00 (YR1) \$0.00 (YR2)
3. Generic Discount: AWP minus 86.00% (YR1) 86.25% (YR2)
4. Generic Dispensing Fee: \$0.00 (YR1) \$0.00 (YR2)
5. Overall Specialty Drugs Discount: AWP minus 20.00% (YR1) 20.25% (YR2)
6. Overall Specialty Drugs Dispensing Fee: \$0.00 (YR1) \$0.00 (YR2)

**Generic Dispensing Rate Guarantee**

(a) The Generic Dispensing Rate Employer receives from PBM will not be less than the following amounts:

**GENERIC PRESCRIPTION DRUGS RETAIL AND HOME DELIVERY PHARMACY**

A minimum of 86.53% (YR1) 86.73% (YR2) of retail drugs and a minimum of 75.95% (YR1) 76.14% (YR2) of home delivery drugs will be dispensed as Generic Drugs.

Generic Dispensing Rate is defined as the total number of Generic Prescription Drug Claims received by PBM divided by the total number of Prescription Drug Claims received by PBM.